MEDICARE HOME HEALTH

HEARING

BEFORE THE

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OVERSIGHT AND INVESTIGATIONS

OF THE

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MEDICARE HOME HEALTH

WEDNESDAY, OCTOBER 29, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 2322, Rayburn House Office Building, Hon. Joe Barton (chairman) presiding.

Members present: Representatives Barton, Ganske, Coburn, Klink, Stupak, and Engel.

Staff present: Matthew Saylor, majority counsel; Chris Knauer, minority investigator; and Penn Crawford, legislative clerk.

Mr. BARTON. If we could come to order—everybody will take a seat.

Today we're going to continue a series of hearings regarding waste, fraud and abuse in the Medicare system. Today we're going to hold a hearing on the Medicare home health benefit and the Health Care Financing Administration's effort to implement the anti-fraud provisions of the recently passed Balanced Budget Act as they relate to home health care.

It is my role as chairman of the Oversight and Investigations Subcommittee to ensure that the taxpayers' hard earned dollars are being carefully spent in the Medicare program and not being used to cover waste, fraud and abuse, which today apparently seems to be an additional cost to doing business in the home health care industry. The home health benefit was established to save money, not to waste money. It was to be a cheaper alternative to lengthy and more expensive hospital stays. Unfortunately, it seems that the rapid growth in the home health care industry—an estimated 100 new home health care agencies have been approved per month until the recent moratorium—has only made the home health care component of Medicare more vulnerable to wasteful practices.

Expenditures for the home health benefit are among the fastest growing components of today's Medicare program. They account for approximately 9 percent of all Medicare spending and they reached more than $16.9 billion in fiscal year 1996. That is five times the $3.5 billion that was spent on the same program, as recently as 1990. At this rate it is expected that expenditures for home health services will exceed $30 billion by the year 2002.

Unfortunately, along with the rapid growth in the number of home health agencies, beneficiaries receiving the benefit and Medicare expenditures, have come the problems with waste, fraud and

abuse. This past July, the HHS Office of the Inspector General, in connection with its Operation Restore Trust Audit of Medicare home heath services, released two reports. Both were very damaging. In the first report, the Office of Inspector General found that nearly 40 percent of all paid claims did not meet Medicare reimbursement requirements—40 percent. In other words, services that were billed were not medically necessary or did not meet the other criteria for Medicare coverage. In its second report, the Office of Inspector General found that more than 25 percent of the Medicare certified home health agencies were problem providers, and while not inherently fraudulent, had abused Medicare funds. These Medicare tax dollars should be funding home health care for the elderly and should not be used as a slush fund for unscrupulous providers.

In an effort to stop the bleeding in the home health industry, on September 15 of this year, President Clinton and Secretary Shalala of HHS, announced an unprecedented moratorium on the entry of any new home health agencies into Medicare. This may or may not be a good idea. Whatever the merits of the idea, policy should drive the decision, not politics. An e-mail produced to the committee by the Department which was written by an HHS attorney states, "I thought it might be useful to share with you the legal advice we have provided to HCFA as it tries to find a way to respond positively to White House desires to impose a moratorium on the certification of home health agencies for the Medicare program. We were first approached last week with the moratorium idea and, at first, we were somewhat skeptical..." At the time this e-mail was written, HCFA had just rejected the Inspector General's recommendation that HCFA impose a moratorium. In rejecting the Office of Inspector General's recommendation from HHS, HCFA stated, "We nonconcur. HCFA has the responsibility to establish and implement program requirements and safeguards. If a home health agency is able to comply with these requirements, it should be allowed to enter the Medicare program."

Again, the moratorium on new home health care agencies may or may not be a good idea. On the one hand, it gives the agency the opportunity to catch up and get its compliance program in order. On the other hand, it allows unscrupulous providers already in the system to continue to be in the system, and to some extent, to have a—if not a monopoly—an oligopoly situation, where they can charge without fear of new competition coming into the marketplace. In any event, this about-face in the span of 2 weeks is illustrative of HCFA's lack of leadership, to date, in fighting waste, fraud and abuse and raises concern that this moratorium may have been developed more for White House political purposes with no clearly defined relationship to a broader strategic effort.

This subcommittee, in a bipartisan manner, is committed to that broader, strategic effort. To further that effort, I had a very encouraging meeting last week with Ms. Nancy-Ann Min DeParle, who is currently awaiting confirmation as the new Administrator of HCFA—and know that she is eager to begin weeding out the waste, fraud and abuse that is currently plaguing the Medicare home health care system. Therefore, I look forward to working with the new Administrator as soon as the other body confirms her, and hope that she can provide the leadership that HCFA so desperately

needs. I have high hopes that she will garner a sterling reputation for zero-tolerance in fighting waste, fraud and abuse as HCFA Administrator. It is time for HCFA to stop seeing itself as the agency that is responsible for merely being a claims processor. HCFA, instead, must take the leading role in fighting the waste, fraud and abuse that has become so commonplace and is threatening the very existence of our Medicare program.

Administrative pronouncements and the greater authority given to HCFA under the Balanced Budget Act to fight these problems are one thing; actually following through is quite another. Unfortunately, as has been evident so far in the past, HCFA has a tendency to drag its feet when change is in the air. HCFA may have good intentions, as with the implementation of the Medicare Transaction System, but rhetoric is not going to save the taxpayers one thin dime. I believe that HCFA has some good ideas and I certainly know that the Congress has more than held up its end of the deal, so far. It is now time for the Congress and HCFA to work together and act effectively and in a timely manner. If not, the measures such as the recently announced moratorium by President Clinton, will be nothing more than window dressing.

That said, I am pleased to have with us today representatives from the FBI, Health and Human Services Office of the Inspector General, the General Accounting Office—all of which have been following the problem and attacking it on the front lines and will give us suggestions on how to better police the problem. We will also be hearing from a representative from HCFA and hopefully we'll get a real commitment from them that the authority provided in the Balanced Budget Act will not go to waste, but instead there will be real changes implemented in a manner that will assure program integrity. On our last panel, we will hear from the home health industry and get their side of the story and discuss any suggestions or concerns that they may have.

I would welcome my ranking member, Mr. Klink of Pennsylvania, for an opening statement.

Mr. KLINK. Thank you, Mr. Chairman, and I commend you for taking a look at what is a very serious subject.

In 1996, almost 4 million Americans received home health care and that represents about $20 billion in Medicare expenditures. Once this represented only about 1 percent of the Medicare spending; home health accounts now for about 10 percent of the Medicare dollars and some believe the industry is only going to continue to grow. In 1989, Medicare home health payments have grown by more than 30 percent per year, since 1989. According to recent testimony by the Health Care Finance Administration, as many as 100 new home health care providers were entering into the market each month this year.

Deciding on what we want the home health care industry to be is a critical step toward fixing the current problems. After all, does any even know what a home health care provider is supposed to look like? Do we have a definition? What kinds of services do we want to provide and how much are we willing to spend? What professional care giver standards should we hold them to and who should develop those standards? How large or how small can a provider be and still maintain quality services? How should home

health care be regulated and are the States or the Federal Government equipped to do that job? Without knowing what we want from the industry, we will only continue to attract a mixed bag of providers with a range of reputations and abilities.

Although no part of the health care industry is fully immune from fraud and abuse or from waste, the home health care industry does provide a number of unique opportunities for ripoffs and as the Department of Health and Human Services Inspector General notes in her testimony today, home health care is a $20 billion program that grew too fast with an inherently vulnerable payment structure and inadequate controls, and the evidence clearly seems to support that statement. Investigations by the Department of Health's Inspector General, the General Accounting Office and the FBI continually uncover a range of schemes in the home health industry. These include billing Medicare for services that have not been rendered, billing Medicare for beneficiaries not even remotely definable as homebound, upcoding submissions, visits to a higher reimbursement category, illegal cost shifting, creating fictitious ghost employees and other expenditures for Medicare reimbursements, creating shell companies to bill for products that were never delivered, and on and on and on. I could continue, but I won't. I could also describe the many actual cases that have been made public, demonstrating these schemes, but I'll leave that to the many excellent witnesses that the majority has called before us today.

A number of reasons contribute to the fraud, the vulnerability of the home health care industry. Among the most significant is, that only a small number of such agencies are ever audited by Medicare contractors and, thus, the chances of being caught seem only to be slight. For example, in 1988, when the industry had a much smaller number of providers and beneficiaries, HCFA asked the government's fiscal intermediaries to review almost 50 percent of all claims; today, the same intermediaries now target between only 1 and 2 percent of those same submissions.

Other controls in the home health industry are also seriously lacking. Because beneficiaries of home health are not required to make a co-payment, patients are less likely to complain about services not rendered or even needed. Because beneficiaries do not receive an Explanation of Medicare Benefits, many are totally unaware of what services are being provided and thus, what charges ultimately are being billed to Medicare.

The ease of the entry into the home health care market is yet another problem that contributes to the industries susceptibility to fraud and abuse. Stories of providers operating businesses out of kitchen pantries or from the trunks of cars, have become commonplace. Stories of providers with an extensive criminal background, even active drug dealers that have entered the home health care market, have become all too frequent.

Mr. Chairman, indeed, some have said that this is an industry that is out of control and I'm not sure, after I've read the testimony of some of those that who are here before us today, that that's an exaggeration. Just recently after a host of home health care horror stories, President Clinton announced a moratorium on new entries into the home health care market until the government can regain

control. While in spirit I applaud this effort, I look forward to discussing with HCFA the moratorium's intent, how long it's needed and how it came about. I do note that it's implementation represents how desperate this situation has become. I also look forward to discussing with our witnesses whether some of the intended fixes implemented during the moratorium—and there are many—will be significant enough to provide the necessary regulatory framework so lacking today.

So, Mr. Chairman, let me conclude by providing a very needed qualifier to my statement. Although the words that I've uttered here this morning have had a rather negative focus on the problems plaguing this industry, the level of abuse reportedly connected to the home health care industry has me greatly concerned. When the Inspector General makes the claim that in a recent audit of four major beneficiary States, that more than 40 percent of all claims have been improperly paid, then I say we have a very serious problem, requiring very serious attention.

Nevertheless, I have to add that there are many solid providers in the home health care market and many of them are with us today. I look forward to their testimony and further, I think it's important to underscore the need for the services they provide to the many communities across this Nation and I sincerely thank them for that. I hope that, as a Congress, we're able to work with them to address many of the issues that are now being faced by the home health care industry.

Mr. Chairman, I thank you, and yield back the remainder of my time.

Mr. BARTON. We thank you, Congressman Klink. We now recognize Dr. Tom Coburn of Oklahoma for an opening statement.

Mr. COBURN. Thank you, Mr. Chairman. Every now and then we get to have hearings on things we know a little bit about. I know a lot about home health care. What I know is, is it's a system that is designed by Congress to be defrauded. It is Congress' responsibility to change that. We can hammer, we can say that HCFA isn't doing their job, but until we take the perverse incentives out of this program that cause people to defraud it, we're not—it doesn't matter how big HCFA is, it doesn't matter how good HCFA is—they're never going to keep up with it, because they're always going to be one step ahead.

Congress has the wonderful habit of fixing the wrong problem and I hope that's not the result of this meeting. We're not going to fix home health until we define what homebound is. It's never going to be fixed, because you're going to continue to have a spurious definition that will be open to interpretation, that can be documented falsely, but still can be documented and people can still be defrauding the system. We have great home health care companies out there. We have some crooks; there is no question about it. But the way to get rid of them is to redesign the system and take the incentives out of it.

I appreciate the testimony of those that are here today. Be prepared for some hard questions, because we're going to have them. We had a committee vote on home health care in the whole Commerce Committee when we were redoing Medicare this time and, unfortunately, I didn't prevail in trying to redesign what the defini-

tion for homebound was, which the Congress set initially. It's my hope that, through hearings like this, that we can raise the level of knowledge in the Congress and lower the level of fear by the Members of Congress, so that they can do what's right to fix this problem. You know, when $8 billion is going out of Medicare each year, fraudulently, just in this one program, it's a disservice to the very seniors we say that we are supporting, by not fixing this program.

So, I welcome you, I thank the chairman for holding this hearing and I can't wait for us to get some results out of it.

Mr. BARTON. Does that conclude your opening statement?

Mr. COBURN. Yes, sir.

Mr. BARTON. Well, we certainly thank you, Dr. Coburn, and your expertise in this field is going to be extremely important as we go through not just this hearing, but a number of hearings and develop recommendations.

I want to welcome our first panel. I think each of you know that it's tradition of this subcommittee to take all testimony under oath. Do any of you oppose that? Okay.

You also have the right, under the Constitution of the United States and the rules of the Congress and of this subcommittee, to be advised by counsel during your testimony. Do any of you have a counselor with you and, if so, we need to have that person also sworn? Okay.

Will each of stand, then, and please raise your right hand.

[Witnesses sworn.]

Be seated. We have your written statement. They will be submitted in their entirety for the record. We're going to ask that you summarize the written statements and try to summarize them in, I'm going to say, about 7 minutes. If you go a little bit longer that'll be okay, but the little bell will ring at 7 minutes.

We're going to start with the Honorable June Gibbs Brown, who is the Inspector General at the Department of Health and Human Services. We're honored to have you with us and you'll be recognized for 7 minutes.

TESTIMONY OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL; ACCOMPANIED BY GEORGE F. GROB, DEPUTY INSPECTOR GENERAL, OFFICE OF EVALUATIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES; WILLIAM J. SCANLON, DIRECTOR, HEALTH SYSTEMS ISSUES, GENERAL ACCOUNTING OFFICE, AND CHARLES L. OWENS, CHIEF, FINANCIAL CRIMES SECTION, FEDERAL BUREAU OF INVESTIGATION

Ms. BROWN. Good morning, Mr. Chairman. I'm June Gibbs Brown, Inspector General for the Department of Health and Human Services and with me is George F. Grob, Deputy Inspector General for Evaluation and Inspections.

I'm here today to describe the status of efforts to gain control over the Medicare home health benefit. This is a $20 billion program that has been very important to our elderly and disabled citizens, but it grew very fast with inadequate controls. The result is widespread waste, fraud and abuse. In July, I reported that 40 percent of Medicare home health payments in California, New York, Illinois, and Texas have been improperly paid and this represents

a Medicare loss of $2.6 billion over a 15 month period in just these four States.

There are no natural controls in this program. Neither the service providers, nor the physicians who authorize the services, nor even the beneficiaries themselves have incentives to control costs. Furthermore, formal controls, such as the enrollment and payment review processes, are weak. The sheer volume of claims makes it difficult for Medicare's fiscal intermediaries to review claims adequately. As a result, home health agencies who desire to exploit the cost reporting and payment system can do so easily.

We found that 25 percent of home health agencies in five States had a history of significant, uncollected overpayments, unreliable and unauditable cost reports, medically unnecessary services, services billed, but not rendered, significant certification deficiencies, or referrals to program integrity or fraud units. These, what we are calling problem providers, received 45 percent of the total home health expenditures in those States in 1995. The States were New York, Florida, Illinois, Texas and California.

Over the years, my office has made numerous recommendations to deal with these problems. We called for a fundamental change in the payment structure and stronger controls. Fortunately, both the Congress and the administration have recently taken forceful action along these lines. The Balanced Budget Act, signed into law August 5, 1997, contains a number of important provisions, including a new prospective payment system which will help to control the rapidly growing cost of home health benefits. Additionally, the President has announced a moratorium on intake of new home health providers while HCFA strengthens the enrollment process and payment safeguards.

In general, these new reforms are responsive to the recommendations we have made. I would suggest just a few refinements, mostly to correct problems in the Federal Bankruptcy laws and to strengthen the role of physicians in approving plans of care.

It is still possible for wrongdoers to use bankruptcy protection as a way to avoid responsibility for repayment of overpayments, fines or penalties, and even to prevent the Secretary from suspending Medicare payments to the provider under investigation for fraud. These loopholes need to be eliminated.

Our studies show that physician are not actively involved in the preparation of patient plans of care, are not aware of Medicare's home health eligibility requirements or rely too much on the home health agencies which provide the care and get reimbursed for it, to prepare detailed plans which they then sign. We recommend that physicians be required to physically examine all patients whose home health care plans they certify, before doing so. We are beginning to solicit other ideas from physician groups on how to strengthen the physician's role. We believe that everyone will gain: patients, physicians, and taxpayers, through a stronger physician involvement.

No doubt there are numerous other steps that can and will be taken to strengthen controls of this program. But, I wish to conclude my statement by emphasizing my support for the recent initiatives of the Congress and the administration. Until they are im-

plemented, Medicare will continue to make significant, improper payments.

I will be happy to answer any questions you may have and submit my detailed statement for the record.

[The prepared statement of Hon. June Gibbs Brown follows:]

PREPARED STATEMENT OF JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

HOME HEALTH—TAKING STOCK

I am June Gibbs Brown, Inspector General, Department of Health and Human Services. I am here today to talk to you about the status of efforts to gain control over the Medicare home health benefit.

This is a $20 billion program that grew too fast, with an inherently vulnerable payment structure and inadequate controls. The result has been annual losses to the Medicare program of billions in misspent dollars. In July, I reported that 40 percent of Medicare home health payments in California, New York, Illinois, and Texas had been improperly paid and that home health providers, if they so desired, could routinely abuse the program by exploiting its cost reporting and payment systems.

Fortunately, both the Congress and the Administration took forceful actions to address the program's most fundamental weaknesses. These include a new prospective payment system, better controls on enrollment of providers, and stronger payment safeguards. The speedy and steadfast implementation of these reforms is primarily what we need at this time. However, I would like to suggest just a few refinements, mostly to strengthen the role of physicians in approving plans of care and to correct problems in the Federal bankruptcy laws.

I will review for you the unfolding of the problems in this program and our growing awareness of them. I will then explain how the recent Congressional and Administration initiatives are responsive to them, and then highlight a few remaining concerns.

GROWTH AND AWARENESS OF TROUBLE

Our concern about home health was initially prompted by the tremendous growth in benefit expenditures. As you probably know, the home health benefit is one of the fastest growing components of the Medicare program. The Health Care Financing Administration (HCFA) estimates that FY 1997 expenditures are almost $20 billion. This is more than five times the $3.5 billion spent in 1990. Home health expenditures now account for 9.2 percent of total Medicare spending compared to 3.5 percent in 1990.

The reasons for the rapid growth of home health expenditures are numerous. Some of the growth is appropriate and expected due to demographics, court cases which have liberalized coverage of the benefit, technological advances such as infusion therapies which can be provided at home, and a trend toward providing more care in the community rather than in institutions. However, the basic design of the program and lack of effective program controls opened the way to waste, fraud, and abuse.

Waste, Fraud, and Abuse

Reports issued by the Office of Inspector General (OIG) and others have repeatedly documented how fraud, waste, and abuse contribute significantly to the high growth of home health expenditures.

Unjustifiable Payment Variation: In a 1995 OIG report, we identified extreme variation in payments to home health agencies. For example, we compared high, medium and low cost home health agencies based on their average reimbursement per beneficiary. In FY 1993, lower cost home health agencies (those which provided less than the national average of visits per episode) averaged 30 visits per episode, whereas the higher cost agencies provided 85. One year later, the lower cost agencies provided 33 visits per episode, while the average for the higher cost agencies jumped to 102. We found no reasons for these differences. For example, we found no differences in beneficiary characteristics, medical conditions, or in the quality of care provided.

Improper Payments: We soon began identifying an exceptional level of inappropriate payments made under this program. Our first evidence came from audit reports and investigations of certain providers suspected of defrauding the program. We also conducted a Statewide audit in Florida in 1995. We found an error rate—the percent

of the home health visits paid for by Medicare but which did not meet Medicare guidelines—of about 20 percent.

New impetus was given to our work by Project Operation Restore Trust, the Secretary's two year anti-fraud demonstration initiative. This was a crackdown on fraud and abuse in the areas of home health, nursing home services, and durable medical equipment in five States—California, New York, Florida, Texas, and Illinois—that account for 40 percent of the nation's Medicare beneficiaries and program expenditures. Audits of specific home health agencies in Florida, Pennsylvania, and California revealed error rates in paid services from 19 to 64 percent. These were due to visits that were not reasonable or necessary, patients who were not homebound, visits which were not documented or even provided to Medicare beneficiaries, improper or missing physician authorizations, and even forged physician signatures.

Our most recent report, "Review of Medicare Home Health Services in California, Illinois, New York, and Texas," was issued on June 28 of this year. In this study, we reviewed 250 claims accounting for 3,745 services from a randomly selected sample of home health agencies in the four heavily populated States in the report's title. For these cases, our auditors interviewed beneficiaries, family members, knowledgeable acquaintances, and certifying physicians and obtained medical review by Medicare's home health intermediary personnel. They found that in those four States, 40 percent of the total services provided during the 15-month period ending March 31, 1996 did not meet Medicare reimbursement requirements. The explanations were similar to those of the earlier audits: unnecessary services, patients not homebound, inadequate physician authorization and lack of supporting documentation. This represents a Medicare loss of $2.6 billion, or 39 percent of the $6.7 billion of the universe of claims represented by the sample.

Problem Providers: We have also found that there are too many inappropriate providers allowed to deliver Medicare home health services. On the same day we issued the Four-State audit just mentioned above, we issued another report, "Home Health: Problem Providers and Their Impact on Medicare." Here we found that 25 percent of home health agencies in New York, Florida, Illinois, Texas, and California met our definition of a problem provider—one with a history of significant uncollected overpayments, unreliable and un-auditable cost reports, medically unnecessary services, services not rendered, significant certification deficiencies, and referrals to program integrity or fraud units. Reimbursement to these agencies is significant, totaling $2.5 billion or 45 percent of total home health expenditures in these States in 1995.

Problem home health agencies have many similar characteristics. In general, they tend to: have higher costs; have owners with little or no health care experience; are family based businesses; have financial interests in other related businesses; and have very few assets, with Medicare as a primary source of income. These agencies use numerous techniques to exploit the program, including putting ghost employees on their rolls and shifting costs from other businesses which they own.

Here we begin to see a picture of a group of providers who are able to generate large profits with very little risk to themselves or their businesses. We are greatly concerned that these home health agencies pose a threat to the home health program and the Medicare trust fund. One illustration of this is that 60 problem agencies that we selected at random and studied in detail have combined outstanding debt of $321 million. Their individual agency overpayments range from $100,000 to several million dollars. Most of these agencies are repeat offenders.

Outright Fraud: Not all the problem providers just discussed are guilty of breaking the law. Because of weak program controls, most of them can abuse the program in ways that are legal but contrary to the intent of the program or without any danger of being found guilty. However, we have found cases where deliberate fraud has been proven. These shed light on how easy it is to defraud the Medicare home health program and how much damage can be caused. Here is a synopsis of some of the investigative cases completed by our office over the past two years:

- The Chief Executive Officer and his wife and co-owner at a Georgia home health agency were convicted of conspiracy to defraud Medicare. They were accused of filing cost reports that included personal expenses, political contributions, ghost employees and lobbying expenses. They were also charged with mail fraud, paying kickbacks, making false statements, witness tampering, money laundering, and submitting false tax returns. The defendants were sentenced to 90 months and 32 months incarceration, respectively. These individuals and the company were ordered to pay $255 million in fines, restitutions, and other penalties.
- The owner of a Louisiana home health agency was sentenced to 5 years probation and ordered to repay $119,000 for defrauding the Medicare program. The owner included in Medicare cost reports the expenses of a costume shop she owned

and a magazine she produced monthly. Expenses charged included payroll, leases, telephone service, and advertising.

- The owner of a Texas home health agency entered a settlement agreement to pay $493,000 in civil damages and penalties for submitting false Medicare claims. Our investigation found that over a 9-month period, the agency billed Medicare for home health services for patients that were not homebound and for services not rendered.

Inadequacy of Traditional Controls

Traditionally the program has looked to the home health intermediaries, certifying physicians, beneficiaries, and service providers to control utilization of the benefit. Our reports highlight the inadequacy of these existing controls over the benefit.

Physicians: Physicians play a questionable role in determining need for or appropriate level of home health services for beneficiaries. Home health agencies tend to perform these activities. In our Four-State audit, we interviewed 136 physicians who had signed the plans of care associated with the unallowable claims found in our review. In 11 cases, the physicians signed the plans of care without having knowledge of the patient's condition. In 82 cases, the physicians said they were not aware of the homebound requirement. In 88 cases the physicians relied on the home health agency to prepare the plan of care.

Intermediaries: The sheer volume of claims and limits on financial resources prevents Medicare's intermediaries from reviewing home health agency claims. In recent years, intermediaries have been asked by HCFA to target between 1 and 3 percent of all claims, including home health claims, for review. This is a significant reduction from 1988 when intermediaries were asked to review 50 percent of home health claims.

By way of contrast, private insurance companies, particularly health maintenance organizations, exercise much closer scrutiny of home health services. Medicare home health organizations do better than Medicare's intermediaries in terms of controlling costs. For example, we found that the health maintenance organizations in our survey provide home health care for Medicare beneficiaries for only one-fourth the cost of the Medicare fee-for-service program. They do this by using case managers to review and approve patient care. The case managers work with physicians to plan care and write orders, review and approve both initial and continuing visits, review medical necessity, track and report outcomes, and participate in quality assurance activities such as clinical record reviews, team meetings, and case conferences. Lack of resources prevent Medicare intermediaries from routinely engaging in such activities.

Beneficiaries: We also found that at the time our work was conducted beneficiaries were unaware of specifically which home health services were claimed on their behalf. However, in October 1996, intermediaries were required to begin issuing a "Notification of Service" to beneficiaries. We hope that providing this information will enable beneficiaries to help in detecting fraud.

OIG Recommendations

Throughout the course of our work, the Office of Inspector General has made numerous recommendations for addressing home health problems. When taken together, we have essentially proposed a three part strategy to deal with the problems we have encountered: 1) restructure the payment system to eliminate inappropriate incentives which unnecessarily increase cost and utilization; 2) prevent unscrupulous providers from gaining entry into the program; and 3) improve program controls such as eligibility determination and approval of plans of care and services. A variety of options are available for all three parts of this strategy. At one time or another, in our reports and testimonies, we have offered the following recommendations:

Restructure the Payment Method: We strongly supported the idea of a prospective payment system for home health. This approach, recently enacted in the Balanced Budget Act of 1997, authorizes a fixed payment per episode for each patient in need of home health services. It eliminates incentives in the current payment system to increase profits by unnecessarily increasing the number of visits provided to a patient. Unfortunately, a prospective payment system may take some time to develop, whereas the need for structural reform is immediate. We have recommended other payment changes that could be used until a prospective payment system has been adopted. Options include: visits caps or limits; cost limits per beneficiary; benefit targeting; limits on expenditures per beneficiary; and beneficiary copayments. Some of these features are included in the Balanced Budget Act, in various levels of stringency.

Keep Problem Providers Out of the Program: Structural reforms alone would not do enough to protect the program from truly unscrupulous providers. For example, providing benefits to ineligible beneficiaries would still allow agencies to bring in undeserved income even if the payment is made on a prospective basis. It is important that HCFA have the ability to identify problem providers and prevent them from abusing the program or even from entering the program. We offered the following options:

- requiring that each home health agency obtain a surety bond equal to the amount of anticipated Medicare billings during its fiscal year.
- requiring that the majority of the home health agency's principals have prior health care experience directly related to the provision of home health services in order to receive Medicare certification.
- developing a data bank of owners, principals, and other home health agency officials and related organizations so that their activity can be monitored, tracked, and cross-referenced.
- requiring that all home health agency owners and principals provide their individual Social Security numbers and Employer Identification numbers when they submit an application to become Medicare providers.
- requiring user fees so that new and existing home health agencies are required to pay for their initial certifications, comprehensive on-site reviews, and recertification.
- prior to certification, assuring that new home health agencies are financially sound and have adequate fiscal record keeping capabilities and that their owners and principals are qualified and trustworthy.
- conducting more extensive background checks to determine the suitability of, and, if appropriate, refusing to enroll, any agency whose owners or principals:
  - —owe money to the Federal government in the form of Medicare overpayments, tax liens, or unpaid loans;
  - —have filed bankruptcy or have negative credit ratings;
  - —have prior criminal records; and/or
  - —have been associated with, or are the relatives of the owner of, a Medicare provider who was found to defraud, abuse, or otherwise misappropriate Medicare dollars.
- precluding the discharge of Medicare debts through bankruptcy.
- continuing to provide beneficiaries with notifications of services provided and using feedback from the beneficiaries to target abusive home health agencies for focused medical review.
- imposing a moratorium on any new certifications until adequate program safeguards have been implemented, unless the home health agency can demonstrate that it will be operating in an under-served area.

Improve Program Controls: Even with competent, trustworthy providers, the day to day management of this benefit will be a daunting task that will require the attention of everyone involved in it—home health agencies, fiscal intermediaries, certifying physicians, even beneficiaries and their families. The following are some specific options we have recommended to improve program operations:

- ensure that patients are truly homebound, for example:
  - —strictly applying the definition of "homebound;"
  - —requiring beneficiaries to certify their "homebound" status; and
  - —developing additional guidance and definitions, such as those pertaining to "considerable and taxing effort" and "infrequent or for periods of relatively short duration."
- improve physician supervision of home health services, in particular:
  - —requiring the patient's physician to examine the patient before ordering home health services and to see the patient at least once every 60 days;
  - —ensuring that the treating physician establish the plan of care and specifically prescribe the type and frequency of services needed; and
  - —better educating physicians on Medicare eligibility requirements so they do not have to rely on the home health agency's determination.
  - —have intermediaries perform focused medical reviews, with physician and beneficiary interviews to verify services.

NEW INITIATIVES

The Balanced Budget Act signed into law August 5, 1997 contains a number of important provisions to help prevent Medicare fraud and abuse and to promote responsible program enforcement. These measures, which include moving to a prospective payment system, will help to control the rapidly growing cost of home

health benefits. Additionally, the President has recently announced a major initiative to crack down on abuse in the home health program. This includes a moratorium on new home health providers while strengthening the enrollment process and payment safeguards.

All of these actions are consistent with and responsive to our recommendations. The combined impact of enactment of the new legislation and the strong administrative action is a very good start to addressing problems in the home health industry.

Prospective Payment System

The most fundamental reform brought about by the Balanced Budget Act is the establishment of a prospective payment system for home health. We have been, and continue to be, strong advocates of such a system. The Act gives the Secretary of HHS authority to establish a prospective payment system for home health services, to be implemented Oct. 1, 1999. Instead of open-ended billing, HCFA will determine, in advance, what it will pay for a unit of service, how many visits will be included in that unit and what mix of services will be provided. Payment for a unit of home health service will be modified by a case mix adjustor to account for variations in cost due to differences in patient case-mix. Under this system, it will no longer be profitable for home health providers to provide unneeded services. Upon implementation of the prospective payment system, periodic interim payments will be eliminated.

The new law also provides for interim price and utilization controls which includes changes to the cost limits and limits on per beneficiary expenditures.

Enrollment of New Providers

Legislative Changes: The Balanced Budget Act also addresses serious vulnerabilities in the process of enrolling home health agencies into the Medicare program. For example, it authorizes HCFA to refuse to enter into contracts with felons. The Secretary could stipulate, for example, that individuals convicted of embezzlement not be allowed to enroll as a Medicare provider even if the conviction did not occur in connection with a health care business. The OIG will also be able to exclude from the Medicare program entities owned or controlled by the family or household members of excluded individuals. For example, some excluded providers have been able to escape the impact of their sanctions by expediting transfers on paper of their ownership and control interests in health care entities to family or household members while retaining true, silent control of the businesses. We were also pleased to see the new "Three Strikes, You're Out" provision that mandates a lifelong exclusion from participation in any Federal health care program for any provider who is found guilty of health care fraud for the third time.

The Act also begins to address the problem of unscrupulous individuals and companies who exploit or cheat the program through sham companies and irresponsible business practices. It requires home health agencies and others to post a surety bond of a minimum of $50,000 as a condition of participation.

Administrative Remedies: On September 15, 1997 the President announced a moratorium on the entry of any new home health agencies into Medicare. While the moratorium is in effect, the Department intends to implement program safeguards included in the Balanced Budget Act, and work on changes in requirements for home health agencies. As I mentioned earlier, we had recommended this as one possible course of action if current controls proved inadequate.

One key change that will be implemented immediately by HCFA is a requirement that home health agencies supply information about related businesses they own. Often, unscrupulous home health agencies funnel fraudulent activities through subsidiaries or front companies that don't really exist.

HHS will also implement the statutory requirement that home health agencies post $50,000 surety bonds before they are certified. A related rule will require new agencies to have enough funds on hand to operate for the first three to six months. These requirements will establish the financial stability of home health providers. Additionally, HCFA will require agencies to serve a minimum number of patients prior to seeking Medicare certification. Serving private-pay patients will demonstrate experience and expertise in the field before an agency is allowed to serve Medicare and Medicaid's vulnerable populations.

The Department also plans to propose regulations that will require home health agencies to re-enroll in Medicare every three years. As part of the re-enrollment process, agencies will be required to submit an independent audit of their records and practices. If the agency does not meet the strict new enrollment requirements, they will not be renewed as providers in Medicare.

Strengthening Payment Controls

The Balanced Budget Act made a number of changes which will strengthen payment controls to better ensure that 1) only people eligible for the home health benefit receive such services; and 2) beneficiaries do not receive services beyond those they truly need. These changes include:

—Requirement that the Secretary conduct a study on the criteria for determining whether an individual is homebound and therefore qualified to receive home health services;
—Clarification of the definition of part-time or intermittent nursing care which specifies the number of hours and days home health care which can be provided;
—Exclusion of venipuncture from qualifying skilled services, so that home health agencies can no longer pad their bills with unnecessary services when a patient simply needs blood drawn; and
—Provision of authority to HCFA to make claim denials based on normative utilization standards. Home health agencies providing significantly more services than the norm would be subject to payment denials.

These strengthened controls will go a long way to identify inappropriate utilization so that any excess utilization patterns are not built into the prospective payment system.

The Act also includes a provision that requires billing of home health services be based on the location of service rather than location of the agency's headquarters. This will stop agencies from getting higher urban reimbursement when, in fact, the service occurred in a lower-cost rural setting.

Other ongoing initiatives that help fight home health fraud are being accelerated. Operation Restore Trust is being expanded. A proposed regulation to require home health agencies to conduct criminal background checks of the aides they hire, and to be more accountable for the care they provide, is nearly complete. Further, as part of its initiative, HCFA will increase the number of claim reviews from 200,000 per year to 250,000. The number of home health agency audits will also double.

REMAINING CONCERNS

Although the Congress and the Administration have implemented most of our recommendations through recent legislation and recent actions, there are many details still to be worked out. We have been advising and will continue to advise HCFA and Congressional staff on implementation of the various provisions of the new law and of the new measures now being developed during the moratorium. Above and beyond that, I would like to raise a few concerns that I believe still need to be addressed.

Eliminate inappropriate bankruptcy protections: One OIG recommendation, which was included in the President's anti-fraud bill but which was not included in the Balanced Budget Act, concerns eliminating home health agencies' ability to discharge Medicare debt through bankruptcy. It is thus still possible for wrong doers to use bankruptcy protection as a way to avoid responsibility for repayment of overpayments, fines, or penalties and in some cases even circumvent a program exclusion. The cases we deal with are not those where a legitimate business declares bankruptcy because of unfavorable economic or business conditions. Rather, the bankruptcy is used subsequent to a fine or penalty to allow the agency to avoid completely any financial responsibility for wrong doing. We are also concerned about using the bankruptcy law to prevent the Secretary from suspending Medicare payments to a provider under investigation for fraud. We hope the Congress will reconsider these proposals soon.

Strengthen physician role: An additional aspect of the home health program that still requires attention is the role of physicians in approving the plans of care for homebound patients. As noted earlier, our studies show that physicians are not actively involved in the preparation of patient plans of care, are not aware of Medicare's home health eligibility requirements, or rely too much on the home health agencies which provide the care and get reimbursed for it to prepare detailed plans which they sign. We have recommended in the past that physicians be required to physically examine all patients whose home health care plans they certify before doing so. We still believe this is a good idea. Other ideas we are now considering are to modify the certification forms, which physicians sign, to spell out more clearly what Medicare's eligibility requirements are and provide an attestation by the physician that they are aware of these requirements and of the patient's condition, and possibly to include on the form the amount of money that Medicare will pay for the patient if the plan of care which the physician certifies is implemented. We are beginning to solicit other ideas from physician groups on how to strengthen the physi-

cian's role. We believe that everyone will gain—patients, physicians, and taxpayers—through better quality of care and less waste.

CONCLUSION

In conclusion, the new initiatives of both the Congress and the Administration will go a long way to solving the serious problems that have plagued Medicare's home health program. I know that many in the industry have concerns about the new procedures now being developed. I can well understand their misgivings. But the problems we have been facing in this program are severe. I do believe the new measures are responsible. Until they are in place, Medicare will continue to make significant improper payments.

This concludes my prepared statement. I welcome any questions that you may have at this time.

Mr. BARTON. Thank you.

I want to notice that Congressman Stupak has joined us. He missed the opening statements, but if he has a written one, it'll be submitted for the record or you can give a very brief—like 1 minute—opening statement right now.

Mr. STUPAK. I'll just ask for unanimous consent to submit it and also in my statement, I'd ask for unanimous consent to put in the amendment I had offered on fraud, waste and abuse during the reconciliation and the consideration thereof, so it's all part of my opening, if that would be sufficient, Mr. Chairman. Thank you.

Mr. BARTON. Without objection.

[The prepared statement of Hon. Bart Stupak follows:]

PREPARED STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Thank you Mr. Chairman for holding this important hearing.

Mr. Chairman, this hearing will encompass two of my greatest passions in healthcare policy: ensuring access to healthcare in rural areas and combating fraud, waste and abuse. Therefore I will be very interested in the testimony of the witnesses on both of these subjects.

Mr. Chairman, the struggle in rural healthcare is ensuring our citizens have access to healthcare. Unlike some areas of the country where there is an oversupply of healthcare providers and a need to decrease the number of health professionals, rural areas are desperately in need of providers. In addition, people who live in rural areas many times have great distances to travel between their home and their doctor. Therefore, these unique features of rural life make home health care incredibly important to my constituents.

I have heard from a number of home health care organizations that the new billing limits will adversely effect patient care in rural areas. Furthermore, they argue that by placing an annual per beneficiary cap, elderly will be forced out of their homes and into nursing homes. I will be interested to hear from the witnesses about these problems that affect rural areas.

Second, I am very concerned about the level of fraud, waste and abuse in the area of home health. Since the witnesses will cite the startling statistics about home health fraud. I will not reiterate their testimony. However, I will point out that the government still needs extra tools in order to effectively fight home health fraud. HCFA will testify today that there are a number of anti-fraud proposals they are requesting legislative action on. I offered an amendment during reconciliation that would have included most of these provisions in the Balanced Budget Act of 1997. These provisions included: extension of subpoena and injunction authority, liability of physicians in specialty hospitals, and the expansion of criminal penalties for kickbacks.

Although my amendment included other anti-fraud tools, HCFA will testify these tools are necessary to continue to decrease fraud. Unfortunately, my amendment was defeated on a party line vote.

Mr. Chairman, I would like to work with you to improve what is arguably the most important program the federal government administers. Combating fraud, waste and abuse should be a bi-partisan goal of this subcommittee. I would hope you would join me in fighting for passage of these provisions, so we can ensure that

Medicare funds go to the treatment of the elderly, not rip-off artists. I ask unanimous consent to have my amendment and a record of its vote included in the record.

Mr. BARTON. We would now like to hear from Mr. William J. Scanlon, who is the Director of Health Systems Issues for the General Accounting Office. Again, your written statement will be submitted for the record in its entirety and we would ask that you would try to summarize it in 7 minutes or less.

TESTIMONY OF WILLIAM J. SCANLON

Mr. SCANLON. Thank you very much, Mr. Chairman. I'm very pleased to be here today as you and the subcommittee consider the issue of the rapid cost growth and the fraud and abuse issues in the Medicare home health benefit. As you've indicated, this benefit has been one of the fastest growing components of Medicare spending. Indeed, it increased over 600 percent since 1989.

The Balanced Budget Act, however, has considerable potential in helping us alleviate some of the problems that have been identified. Its provisions for tighter control on current payments, a requirement for a prospective payment system, curbs on some abusive billing practices and stronger requirements for provider participation, all hold promise for slowing the growth in home health expenditures.

The Health Care Financing Administration has considerable discretion in implementing that law which in turn, means the agency has much work to do in a limited timeframe. I cannot emphasize enough the importance of HCFA doing an effective and timely job in developing and implementing the mechanisms that will better control program costs while creating incentives to continue access to quality services.

I'd like to take a few minutes to elaborate on some of those challenges in developing a prospective payment system and implementing the accompanying program controls. The primary goal of prospective payment is to give providers incentives to control costs and at the same time pay enough and in such a way that we guarantee adequate access and quality services for Medicare home health beneficiaries. If prospective payment is not properly designed, Medicare will not save money; cost control incentives will be at best, weak; and access or quality of care may suffer. Selection of the unit of service for payment and taking account of the varying needs of different patients are very important aspects of prospective payment design, because of the incentives they create.

Paying for episodes of care, rather than visits, seems the logical approach. The cost limits used in the current retrospective system have served as per visit prospective rates for many agencies; however, they have provided little cost control as the numbers of visits has skyrocketed. Paying for an episode of care involving extended periods of time increases the incentives to be efficient and control costs. It also, however, increases the burden on HCFA in developing suitable measures of case mix or patient care needs to adjust the rates paid for different types of patient.

Without an adequate case mix adjuster, agencies that serve populations that on average require less care would end up being overcompensated. Also, agencies would have an incentive to seek out

patients expected to need less care and shun those needing higher levels of care, thus potentially negatively affecting access.

Prospective payment design and implementation are only the first steps. Realizing the benefits of prospective payment will require a continuing investment in oversight. HCFA will need to parallel the design of prospective payment with an effort to design a utilization and quality control system to guard against unscrupulous agencies who attempt to maximize profit by excessively decreasing the number or content of visits within an episode or increasing their caseload, including patients who are not truly eligible for the Medicare home health benefit.

Another challenge is to ensure, in the process of setting prospective payment rates, the reliability of the cost and utilization data for those rates. Historical data used today on utilization and cost of services will be the basis for rates for years to come. So, it is important that today's data be adequate for that purpose. A good design can be overwhelmed by bad data. As the resources devoted to program oversight and review have declined over the years, concerns increased about the quality of the available information. It is, therefore, a positive step, in response to a Presidential directive, that HCFA is planning now to audit about 1,800 home health agencies' cost reports over the next year. If these audits are thorough, that effort could represent a significant step toward improving HCFA's home health cost data base.

Concern, however, also exists regarding the utilization data that will play a key role in defining episodes under prospective payment. As we reported in March, 1996, controls over the use of home health care have been virtually nonexistent. Our report included a number of examples of non-covered services that were billed and paid by Medicare. Because of these problems, it would be prudent for HCFA to consider conducting a thorough, onsite medical review of a projectable sample of agencies to give it a basis to adjust utilization rates in setting prospective payments. We are not aware that such a review is either underway or planned.

The Balanced Budget Act also gives HCFA some new tools, such as the ability to exclude felons and to require surety bonds, that will deal with the vulnerability of the home health benefit by being more selective about the providers allowed to participate. The administration has also recently announced its moratorium, as you indicated, on home health agency certifications, as HCFA revises its conditions of participation in Medicare. This moratorium will only prove useful if HCFA can accomplish the very ambitious agenda of implementing the more rigorous participation requirements that it has proposed, as well as those that are within the Balanced Budget Act.

In conclusion, we believe very strongly that the Balanced Budget Act provides potential for better control of the Medicare home health benefit. Ultimately, realizing that potential though, rests in great part with HCFA's ability to design an effective prospective pay system and the accompanying new utilization and quality control systems and in using the Balanced Budget Act's tools to keep untrustworthy providers from gaining access to the program and to remove those that already have access.

Thank you very much. I'd be happy to answer any questions you or members of the subcommittee may have.

[The prepared statement of William J. Scanlon follows:]

PREPARED STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today to discuss how the Balanced Budget Act of 1997 (BBA)[1] addressed the issues of rapid cost growth in Medicare's home health benefit. The home health benefit is important for many beneficiaries recovering from illness or injury after a hospitalization, the original purpose of the benefit. In recent years, an increasing number of beneficiaries also received under the benefit more custodial-type care for chronic conditions. This change has been a primary contributor to growth in Medicare home health costs, which averaged about 33 percent per year as costs went from about $2 billion in 1989 to almost $18 billion in 1996.

My testimony today focuses on four areas: the reasons for the rapid growth of Medicare home health care costs in the 1990s, the interim changes in the BBA to Medicare's current payment system, issues related to implementing the BBA's requirement to establish a prospective payment system (PPS) for home health care,[2] and the status of efforts by the Congress and the administration to strengthen program safeguards to combat fraud and abuse in home health services. The information presented is based primarily on our analysis of the BBA and on our previous work on Medicare's home health benefit. A list of related GAO products is at the end of this statement.

In brief, changes in law and program guidelines have led to rapid growth in the number of beneficiaries using home health care and in the average number of visits per user. In addition, more patients now receive home health services for longer periods of time. These changes have not only resulted in accelerating costs but also marked a shift from an acute-care, short-term benefit toward a more chronic-care, longer-term benefit.

The recently enacted BBA included a number of provisions designed to slow the growth in home health expenditures. These include tightening payment limits immediately, requiring a PPS beginning in fiscal year 2000, prohibiting certain abusive billing practices, strengthening participation requirements for home health agencies, and authorizing the Secretary of Health and Human Services (HHS) to develop normative guidelines for the frequency and duration of home health services. All of these provisions should help control Medicare costs. However, the Health Care Financing Administration (HCFA), the agency within HHS responsible for administering Medicare, has considerable discretion in implementing the law which, in turn, means the agency has much work to do within a limited time period. HCFA's actions, both in designing a PPS and in implementing enhanced program controls to assure that unscrupulous providers cannot readily "game" the system, will determine to a large extent how successful the legislation will be in curbing past abusive billing practices and slowing the rapid growth in spending for this benefit.

BACKGROUND

To qualify for home health care, a beneficiary must be confined to his or her residence (that is, "homebound"); require intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for part-time or intermittent skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits. Beneficiaries are not liable for any coinsurance or deductibles for these home health services, and there is no limit on the number of visits for which Medicare will pay.

Medicare pays for home health care on the basis of the reasonable costs actually incurred by an agency (costs that are found to be necessary and related to patient care), up to specified limits. The BBA reduced these cost limits for reporting periods beginning on or after October 1, 1997.

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[1] P.L. 105-33, Aug. 5, 1997.

[2] A system in which payment is based on a fixed, predetermined amount per unit.

HOME HEALTH COST GROWTH

The Medicare home health benefit is one of the fastest growing components of Medicare spending. From 1989 to 1996, part A expenditures for home health increased from $2.4 billion to $17.7 billion—an increase of over 600 percent. Home health payments currently represent 13.5 percent of Medicare part A expenditures.

At Medicare's inception in 1966, the home health benefit under part A provided limited posthospital care of up to 100 visits per year after a hospitalization of at least 3 days. In addition, the services could only be provided within 1 year after the patient's discharge and had to be for the same illness. Part B coverage of home health was limited to 100 visits per year. These restrictions under part A and part B were eliminated by the Omnibus Reconciliation Act of 1980 (ORA) (P.L. 96-499), but little immediate effect on Medicare costs occurred.

In 1983, the Medicare PPS for inpatient hospital services was implemented, and many health financing experts expected use of the home health benefit to grow as patients were discharged from the hospital earlier in their recovery periods. However, HCFA's relatively stringent interpretation of coverage and eligibility criteria held growth in check for the next few years. Then, as a result of court decisions in the late 1980s, HCFA issued guideline changes for the home health benefit that had the effect of liberalizing coverage criteria, thereby making it easier for beneficiaries to obtain home health coverage. For example, HCFA policy had been that daily skilled nursing services provided more than four times a week were excluded from coverage because such services were not part-time *and* intermittent. The court held that regardless of how many days per week services were required they would be covered so long as they were part-time *or* intermittent.[3] HCFA was then required to revise its coverage policy. Daily skilled nursing care is now covered for a period of up to 3 weeks. Additionally, another court decision prevented HCFA's claims processing contractors from denying certain physician-ordered services unless the contractors could supply specific clinical evidence that indicated which particular service should not be covered.[4]

The combination of these changes has had a dramatic effect on utilization of the home health benefit in the 1990s, both in terms of the number of beneficiaries receiving services and in the extent of these services. (The appendix contains a figure that shows growth in home health expenditures in relation to the legislative and policy changes.) For example, ORA and HCFA's 1989 home health guideline changes have essentially transformed the home health benefit from one focused on patients needing short-term care after hospitalization to one that serves chronic, long-term care patients as well. The number of beneficiaries receiving home health care has more than doubled in recent years, from 1.7 million in 1989 to about 3.9 million in 1996. During the same period, the average number of visits to home health beneficiaries also more than doubled, from 27 to 72.

In a recent report on home health,[5] we found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits increased from 24 percent to 43 percent and those receiving more than 90 visits tripled, from 6 percent to 18 percent, indicating that the program is serving a larger proportion of longer-term patients. Moreover, about a third of beneficiaries receiving home health care in 1992 did not have a prior hospitalization, another indication of the shift of program focus from beneficiaries needing short-term care following a hospital stay to those receiving care for chronic conditions.

INTERIM CHANGES TO COST REIMBURSEMENT

To gain some measure of control over payments immediately, the BBA made some significant changes to the cost-based reimbursement system used for home health care while HCFA is developing a PPS for the longer term. Home health agency cost limits had been set separately for agencies in rural and urban areas, at 112 percent of the mean costs of freestanding agencies.[6] Limits will now be set at 105 percent of the median costs of freestanding agencies. In addition, the BBA added a limit on the average per-beneficiary payment received during a year. This limitation is based on a blend—75 percent on the agency's 1994 costs per beneficiary and 25 percent

[3] *Duggan v. Bowen, z691 F.Supp. 1487 (D.D.C. 1988).*

[4] *Fox v. Bowen,* 656 F.Supp. 1236 (D.Conn. 1987). This case involved physical therapy services in skilled nursing facilities, and HCFA also applied the principle to home health services.

[5] *Medicare: Home Health Utilization Expands While Program Controls Deteriorate* (GAO/HEHS-96-16, Mar. 27, 1996). This report includes a detailed discussion of the reasons for home health cost growth.

[6] Home health agencies are classified as "freestanding" or "facility-based." Facility-based agencies are those that are a part of hospitals or other institutional providers.

on the average regional per beneficiary costs in that year, increased for inflation in the home health market basket index since then. Hospital-based agencies have the same limits.

The per-visit cost-limit provision of Medicare's reimbursement system for home health agencies gave some incentives for providers to control their costs, and the revised per-visit and per-beneficiary limits should increase those incentives. However, for providers with per-visit costs considerably below their limits, there is little incentive to control costs, and per-visit limits do not give any incentive to control the number of visits. On the other hand, the new per-beneficiary limit should give an incentive to not increase the number of visits per beneficiary above the 1994 levels used to set this limit. However, the number of visits per beneficiary had already more than doubled by 1994 from that in 1989, so the per-beneficiary limits will be based on historically high visit levels. Moreover, per-beneficiary limits give home health agencies an incentive to increase their caseloads, particularly with lighter-care cases, perhaps in some instances cases that do not even meet Medicare coverage criteria. This creates an immediate need for more extensive and effective review by HCFA of eligibility for home health coverage.

DESIGN ISSUES FOR A HOME HEALTH PPS

A PPS, where agencies receive a fixed, predetermined amount per unit, is generally seen as having the potential to improve provider incentives to control costs. Effective and timely design and implementation of the BBA's mandate to implement a PPS for home health services requires considerable HCFA action on several fronts. Issues needing HCFA's attention include selecting an appropriate unit of service, providing for adjustments to reflect case complexity, and assuring that adequate data are available to set the initial payment rates and service use parameters.

The primary goal of a PPS is to give providers incentives to control costs while delivering appropriate services and at the same time pay rates that are adequate for efficient providers to at least cover their costs. If a PPS is not properly designed, Medicare will not save money, cost control incentives will at best be weak, or access to and quality of care can suffer. With the altered incentives inherent in a PPS, HCFA will also need to design and implement appropriate controls to ensure that beneficiaries receive necessary services of adequate quality. Most of the specifics about the home health PPS required by the BBA were left to HCFA's discretion. This delegation was appropriate because insufficient information was available for the Congress to make the choices itself.

Selecting the Unit of Service

Many major decisions need to be made. First, HCFA must choose a unit of service, such as a visit or episode of care, upon which to base payment. A per-visit payment is not a likely choice because it does little to alter home health agency incentives and would encourage making more, and perhaps shorter, visits to maximize revenues. An episode-of-care system is the better choice, and HCFA is looking at options for one.

Designing a PPS based on an episode of care also raises issues. The episode should generally be long enough to capture the care typically furnished to patients, because this tends to strengthen efficiency incentives. A number of ways to accomplish this goal exist. For example, HCFA could choose to set a constant length of time as the episode. In 1993, to cover 82 percent of home health patients, the episode would have to have been long enough to encompass 90 visits, which, assuming four visits a week on average, would mean an episode of about 150 days. Because of the great variability across patients in the number of visits and length of treatment, this alternative places very great importance on the method used to distinguish the differences among patients served across home health agencies in order to ensure reasonable and adequate payments.

Another option for defining an episode of care is to vary the length of the period on the basis of patient characteristics such as the primary condition affecting the patient, other complicating conditions, and any limitations in performing the activities of daily living. For example, a healthy person recovering from a broken leg would normally need a short recovery period with mainly physical therapy, while a patient with arthritis recovering from the same injury might need a longer period with perhaps more home health aide services. This option would also require a good method for classifying patients into the various patient categories and determining resource needs. A third option is to use a fixed but relatively brief period, such as 30 or 60 days, sufficient to cover the needs of the majority of patients, with subsequent periods justified by the patient's condition at the end of each period. The effectiveness of this option would, among other things, depend on a good process for

verifying and evaluating patient condition periodically and adequate resources to operate that process.

Also, HCFA will need to design a utilization and quality control system to guard against decreases in visits, which could affect quality, and home health agencies treating patients who do not quality for benefits. This will be necessary because an episode-of-care system gives home health agencies an incentive to maximize profits by decreasing the number of visits during the episode, potentially harming quality of care. Such a system also gives agencies an incentive to increase their caseloads, perhaps with patients who do not meet Medicare's requirements for the benefit. The effectiveness of PPS will ultimately depend on the effective design of these systems and devoting adequate resources to operate them.

Adjusting for Case Complexity

Another major decision for HCFA, closely related to the unit-of-service decision, is the selection and design of a method to adjust payments to account for the differences in the kinds of patients treated by various home health agencies, commonly called a case-mix adjuster. Without an adequate case-mix adjuster, agencies that serve populations that on average require less care would be overcompensated. Also, agencies would have an incentive to seek out patients expected to need a low level of care and shun those needing a high level of care, thus possibly affecting access to care. Currently, there is limited understanding of the need for, and content of, home health services and, at the same time, a large variation across agencies in the extent of care given to patients with the same medical conditions. HCFA is currently testing a patient classification system for use as a case-mix adjuster, and the BBA requires home health agencies to submit to HCFA the patient-related data HCFA will need to apply this system. However, it is too early to tell whether HCFA's efforts will result in an adequate case-mix adjuster.

Ensuring an Adequate Database for Calculations

A third challenge for HCFA is the need to improve its home health databases so that they will represent an adequate foundation for setting PPS rates. Historical data on utilization and cost of services form the basis for calculating the "normal" episode of care and the cost of services, so it is important that those data are adequate for that purpose. Our work and that of the HHS Inspector General has found examples of questionable costs in home health agency cost reports. For example, we reported in August 1995 on a number of problems with contractor payments for medical supplies such as surgical dressings, which indicate that excessive costs are being included and not removed from home health agency cost reports.[7] Also, the Inspector General found substantial amounts of unallowable costs in the cost reports of a large home health agency chain, which was convicted of fraud on the basis of these findings. Earlier this year, we suggested that it would be prudent for HCFA to audit thoroughly a projectable sample of home health agency cost reports. The results could then be used to adjust HCFA's cost database to help ensure that unallowable costs are not included in the base for setting prospective rates.

In response to a presidential directive, HCFA is planning to audit about 1,800 home health agency cost reports over the next year, about double the number that it otherwise would have audited. If these audits are thorough and the results are properly used, this effort could represent a significant step toward improving HCFA's home health cost database. A good cost database could be a considerable aid to HCFA in calculating the initial payment rates under PPS.

We are also concerned about the appropriateness of using current Medicare data on utilization in designing a PPS. As we reported in March 1996, controls over the use of home health care are virtually nonexistent.[8] Our report included a number of examples of noncovered services that were billed to Medicare. For example, a physician called a claims processing contractor to complain that some of his patients were being told by a home health agency that they were "homebound" merely because they did not own a car. In another study, we found that some home health agency staff had been directed to alter or falsify medical records to ensure continued or prolonged visits, including recording visits that were never made or noting that patients were homebound even after they were no longer confined to their homes.[9] In another study of home health claims, we asked the fiscal intermediary in Califor-

[7] *Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements* (GAO/HEHS-95-171, Aug. 8, 1995).

[8] GAO/HEHS-96-16.

[9] *Medicare: Allegations Against ABC Home Health Care* (GAO/OSI-95-17, July 19, 1995).

nia to perform a medical review of 80 high-dollar claims it had previously processed. The intermediary found that it should have denied 46 of them in whole or in part.[10]

Also, Operation Restore Trust, a joint effort by federal and several state agencies to identify fraud and abuse in Medicare and Medicaid, found very high rates of noncompliance with Medicare's coverage conditions. For example, in a sample of 740 patients drawn from 43 home health agencies in Texas and 31 in Louisiana that were selected because of potential problems, some or all of the services received by 39 percent of the beneficiaries were denied. About 70 percent of the denials were because the beneficiary did not meet the homebound definition. Although these are results from agencies suspected of having problems, they illustrate that substantial amounts of noncovered care are likely to be reflected in HCFA's home health care utilization data. Because of these problems, it would also be prudent for HCFA to conduct thorough on-site medical reviews, which increase the likelihood of identifying whether patients are eligible for services, of a projectable sample of agencies to give it a basis on which to adjust utilization rates for purposes of establishing a PPS. We are not aware that such a review is under way or planned.

SAFEGUARDS AGAINST FRAUD AND ABUSE STILL NEEDED

A PPS for home health should enable Medicare to give agencies increased incentives to control costs and to slow the growth in program payments. A reduction in program safeguards contributed to the cost growth of the 1990s, and HCFA will need to develop a utilization and quality control program to protect against the likely incentives that agencies will have to increase caseloads unnecessarily and to diminish care, and harm quality. Moreover, a PPS alone will not eliminate home health fraud and abuse. Continued vigilance will be needed, and the BBA gives HCFA additional tools that should help it protect the program.

Reduced Program Safeguards Made the Program Vulnerable

Rapid growth in home health expenditures in the 1990s was accompanied by decreased, rather than increased, funding for program safeguard activities. For example, our March 1996 report found that part A contractor funding for medical review (review of claims for medical necessity) had decreased by almost 50 percent between 1989 and 1995.[11] As a result, while contractors had reviewed over 60 percent of home health claims in fiscal year 1987, the contractors' review target was lowered by 1995 to 3.2 percent of all claims (or even, depending on available resources, to a required minimum of 1 percent). We found that a lack of adequate controls over the home health program, such as little contractor medical review and limited physician involvement, makes it nearly impossible to know whether the beneficiary receiving home care qualifies for the benefit, needs the care being delivered, or even receives the services being billed to Medicare. Also, because of the small percentage of claims selected for review, home health agencies that bill for noncovered services are less likely to be identified than was the case 10 years ago.

In addition, because relatively few resources had been available for auditing end-of-year provider cost reports, HCFA has little ability to identify whether home health agencies were charging Medicare for costs unrelated to patient care or other unallowable costs. Because of the lack of adequate program controls, some of the increase in home health costs likely stemmed from abusive practices. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[12] recently increased funding for program safeguards. However, per-claim expenditures will remain below the level in 1989, after adjusting for inflation. We project that in 2003, payment safeguard spending as authorized by HIPAA will be just over one-half of the 1989 per-claim level, after adjusting for inflation.

Finally, as discussed earlier, a PPS will give home health agencies incentives to increase the number of patients they treat and to cut back on the amount of care furnished to patients in order to maximize profits. To safeguard against the new incentives of a PPS, HCFA needs to implement utilization and quality control systems specifically designed to address the PPS's incentives. Without adequate monitoring, home health agencies that choose to do so could game the system to maximize profits or take actions that reduce quality.

New Anti-Fraud-and-Abuse Provisions and Initiatives

The Congress and the administration recently have taken actions to combat fraud and abuse in the provision of and payment for Medicare home health services.

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[10] *Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings* (GAO/HEHS-97-108, June 13, 1997).

[11] GAO/HEHS-96-16.

[12] P.L. 104-191, Aug. 21, 1996.

Through BBA, the Congress has given HCFA some new tools to improve the administration of this benefit. The administration also has recently announced a moratorium on home health agency certifications as HCFA revises the criteria for certification.

BBA Provisions

The BBA included several provisions that could be used to prevent untrustworthy providers from entering the Medicare home health market. For example, BBA authorizes HHS to refuse to allow individuals or entities convicted of felonies from participating in Medicare. Also, Medicare can exclude an entity whose former owner transfers ownership to a family or household member in anticipation of, or following, an exclusion or cause for exclusion. In addition, BBA requires entities and individuals to report to HCFA their taxpayer identification numbers and the Social Security numbers of owners and managing employees. This should make easier the tracking of individuals who have been sanctioned under the Social Security Act or convicted of crimes, if they move from one provider to another.

Another provision of the BBA that may prove useful in fighting fraud and abuse is the requirement that any entity seeking to be certified as a home health agency must post a surety bond of at least $50,000. This should provide at least minimal assurance that the entity has some financial and business capability. Finally, BBA authorizes HCFA to establish normative guidelines for the frequency and duration of home health services and to deny payment in cases exceeding those guidelines.

One area where changes could help to control abuse in home health not directly addressed by the BBA is the survey and certification of agencies for participation in Medicare. State health departments under contract with HCFA visit agencies that wish to participate in Medicare to assess whether they meet the program's conditions of participation—a set of 12 criteria covering such things as nursing services, agency organization and governance, and medical records—thought to be indicative of an agency's ability to provide quality care.

When Medicare was set up, it was not done with abusive billers and defrauders in mind. Rather, Medicare's claims system assumes that, for the most part, providers submit proper claims for services actually rendered that are medically necessary and meet Medicare requirements. For home health care, the home health agency usually develops the plan of care and is responsible for monitoring the care provided and ensuring that care is necessary and of adequate quality. In other words, the agency is responsible for managing the care it furnishes. While these functions are subject to review by Medicare's regional home health intermediaries, only a small portion of claims (about 1 percent) are reviewed, and most of those are paper reviews of the agency's records.

Early this year, HCFA proposed regulations to modify the home health conditions of participation and their underlying standards. The modifications would change the emphasis of the survey and certification process from an assessment of whether an agency's internal processes are capable of ensuring quality of care toward an assessment that includes some of the outcomes of the care actually furnished. HCFA believes this change in emphasis will provide a better basis upon which to judge quality of care. HCFA is currently considering the comments received on the proposed revisions in preparation for finalizing them, but it does not yet have a firm date for their issuance.

We believe that the survey and certification process could be further modified so that it would also measure agencies' compliance with their responsibilities to develop plans for, and deliver, only appropriate, necessary, covered care to beneficiaries. Such modifications could be tied to the new features that HCFA selects as it designs the home health PPS. For example, the case-mix adjuster might be designed to take into account the specific illnesses of the patients being treated along with other factors that affect the resources needed to care for patients, such as limitations in their ability to perform the activities of daily living. Agencies would have a financial incentive to exaggerate the extent of illness or limitations because doing so would increase payments. The survey teams might be able to evaluate whether the agency being surveyed had in fact correctly classified patients at the time the outcome information is reviewed. Use of state surveyors for such purposes would not be unprecedented because survey teams also assessed whether Medicare home health coverage criteria were met during Operation Restore Trust.

As discussed previously, HCFA needs to design utilization review systems to ensure that, if home health agencies respond inappropriately to the incentives of PPS, such responses will be identified and corrected. HCFA should also consider as it designs such systems using the survey and certification process to measure whether home health agencies meet their utilization management responsibilities. This

would help to identify abusive billers of home health services while at the same time help to ensure quality.

Moratorium on New Certifications

On September 15, 1997, the administration announced a moratorium on the admission of new home health agencies to the Medicare program. HCFA noted in testimony earlier this month that the moratorium was called in response to reports of "the steadily increasing volume of investigations, indictments, and convictions against home health agencies." According to HCFA, the moratorium is designed to stop the admission of untrustworthy providers while HCFA strengthens its requirements for entering the program.

In a September 19 memorandum, HCFA clarified the provisions of the moratorium. According to the memorandum, the moratorium applies to new home health agencies and new branches of existing agencies. It will last until the requirements to strengthen the home health benefit have been put in place, which HCFA officials estimate to be in 6 months. No new federal or state surveys are to be scheduled or conducted for the purpose of certifying new home health agencies; those surveys in progress but not completed when the moratorium was announced are to be terminated; and previously scheduled surveys for new certifications are to be canceled. HCFA will, however, enter into new home health agency provider agreements if the new agency has completed the initial survey successfully, meaning that the agency has complied with Medicare's conditions of participation and has satisfied all other provider agreement requirements. HCFA said it would make rare exceptions to the certification moratorium if a home health agency provides compelling evidence demonstrating that the agency will operate in an underserved area that has no access to home care.

According to a HCFA official, several actions are planned during the moratorium. HHS is expected to implement the program safeguards mandated by the BBA, such as implementing the requirement for home health agencies to post at least a $50,000 surety bond before they are certified and promulgating a rule requiring new agencies to have enough funds on hand to operate for the first 3 to 6 months. HHS is also expected to develop new regulations requiring home health agencies to provide more ownership and other business-related information and requiring agencies to reenroll every 3 years.

At this point, it is difficult to say what practical effect the moratorium will have on the home health industry or the Medicare program. However, the moratorium could be useful, first, in sending a signal that the administration is serious about weeding out untrustworthy providers and, second, in establishing a milestone for issuing regulatory reforms.

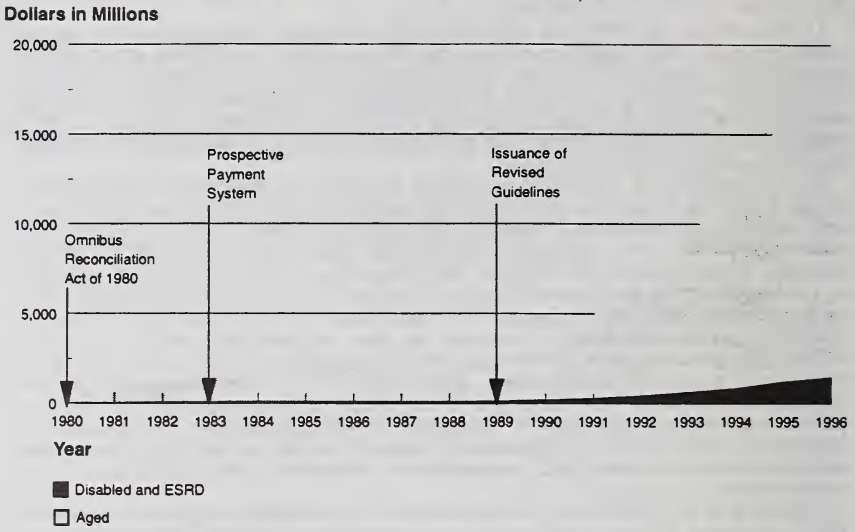
CONCLUSION

To achieve the intended goals of the cost control and anti-fraud-and-abuse initiatives of the BBA, HCFA will have to take effective and timely actions to implement the initiatives. HCFA needs to select an appropriate unit of service and an adequate case-mix adjuster for a PPS as well as remove the effects of cost report abuse and inappropriate utilization from its databases so that those problems do not result in overstatement of PPS rates. HCFA also needs to quickly implement the new tools in the BBA so that it can keep untrustworthy providers from gaining access to the program and remove those that already have access. Moreover, HCFA needs a new utilization and quality control system designed specifically to address the new incentives under PPS.

This concludes my prepared remarks, and I will be happy to answer anyquestions you or Members of the Subcommittee may have.

APPENDIX

MEDICARE HOME HEALTH EXPENDITURES, 1980-96



Note: ESRD = end-stage renal disease.
Source: HCFA's Office of the Actuary.

Mr. BARTON. Thank you, Mr. Scanlon. We are now going to hear from Mr. Charles Owens, who is the chief of the Financial Crimes Section of the FBI. Again, your written statement is submitted in its entirety and we'll ask you to summarize in 7 minutes or less.

TESTIMONY OF CHARLES L. OWENS

Mr. OWENS. Thank you, Mr. Chairman, and thank you for inviting me to testify before your subcommittee this morning.

The FBI has conducted health care fraud investigations for several years, but in 1991, due to the severity of the problem, health care fraud investigations were designated a national priority in the white-collar crime program, the FBI's largest investigative program. The FBI has broad-based investigative jurisdiction to conduct health care fraud investigations, investigating frauds committed against both government sponsored programs, such as Medicare and Medicaid, and frauds committed against privately insured health care programs. While investigations have shown us that no segment of the health care delivery system is immune from fraud, certain segments appear to be exceptionally vulnerable. Included in this category is home health care.

The FBI is presently conducting over 50 separate investigations of allegations of substantial home health fraud. Problems associated with billing in home health care have been recognized by Congress and the administration. Measures included in the Balanced Budget Act of 1997, as well as actions taken in recent months by the administration are extremely positive steps which I believe, along with aggressive criminal investigation, will reduce home health fraud.

In the brief time I have today, I would like to discuss to the extent I can, two ongoing investigations, both in the southern district of Florida, focusing on home health care fraud.

Just 2 months ago, 12 individuals, including two former Dade County administrators of Mederi, Incorporated, one of the Nation's largest home health care agencies, were indicted for allegedly creating a large network of bogus nursing groups to fraudulently bill Medicare. The Mederi administrators allegedly had hidden ownership in these nursing groups and along with other secret owners, submitted the Medicare billings through Mederi. The indictment charges the defendant submitted bills for persons they knew were not qualified to receive those services and that, in many instances, little or no service was ever provided. Last Friday, five additional individuals were indicted and arrested in this investigation. While all the defendants are presumed innocent until proven guilty, this case is important because of the high number of persons alleged to have participated in the scheme and the substantial billings involved, estimated at $15 million. This investigation, which has been ongoing for several years, was conducted by the FBI with the assistance of the Internal Revenue Service in pursuing the money-laundering activity.

In another matter, recognizing the high level of criminal activity in the home health area, the FBI utilized the undercover technique and in 1995 set up its own home health care agency. While this investigation has recently gone overt, it is ongoing and I cannot go into great detail about it. However, two individuals were indicted and arrested in September for money-laundering activity associated with this operation and I'm confident numerous additional individuals will be charged. I should point out that the Health Care Financing Administration was very cooperative with us in carrying out this operation.

This investigation is important because it clearly shows the willingness of the FBI to use sophisticated techniques, such as undercover operations in these complex investigations which enable us to develop the best evidence possible of the fraudulent activity, as well as the scope of the fraud.

Mr. Chairman, as my comments indicated, the FBI is committed to aggressively investigate home health fraud and other egregious health care frauds which have to be underwritten by the public. We will continue to work closely with other investigative agencies and prosecutors and we do so in task forces throughout the country, as well as the Health Care Financing Administration, in combating this problem.

Again, I thank you for inviting me this morning and I'd be happy to answer any questions.

[The prepared statement of Charles L. Owens follows:]

PREPARED STATEMENT OF CHARLES L. OWENS, CHIEF, FINANCIAL CRIMES DIVISION, FEDERAL BUREAU OF INVESTIGATION

Good morning Mr. Chairman and members of the Subcommittee on Oversight and Investigations.

The FBI is aware of this subcommittee's long standing interest and efforts in eliminating waste, fraud, and abuse in the Medicare and other health care plans. I am pleased to be here today and I am committed to working with this committee and all of Congress to combat the health care crime crisis.

No segment of the health care delivery system is immune from fraud, however, this morning I would like to focus on one particular area and that is home health care. As the committee is aware, we have witnessed tremendous growth in home health care. Since 1990, the medicare expenditures for home health agency services have increased dramatically from about $3.3 billion to an estimated $16.9 billion for 1996.[1]

Investigations conducted by the FBI and the Department of Health and Human Services (HHS), Office of Inspector General (OIG), have uncovered fraud schemes in home health care involving cost reporting fraud; billing for services not rendered; up-coding visits to a higher reimbursement code, such as a skilled nursing visit; and billing for services rendered to persons not "home bound" as required by medicare. a number of factors may contribute to the high rate of fraud detected in the home health industry. A relatively small percent of the home health agencies receive on-site audits by Medicare contractors and the beneficiaries are not required to make a co-payment, making it less likely that a beneficiary will complain about the extent of service or what is actually being billed to Medicare.

During an audit by the Medicare branch of Blue Cross and Blue Shield of Iowa, then known as IASD Health Services Corp., numerous discrepancies were discovered in the cost reports of one home health agency. A subsequent investigation by the FBI revealed that this home health agency had submitted false invoices in support of their cost report. Also, contracts for services totaling over $250,000 were issued to family members and friends, but no actual services were rendered. Further, payroll checks in excess of $500,000 were issued to individuals not on the employee list. The owners of this agency, who were reimbursed by Medicare in excess of $10 million from 1993 to 1995, subsequently pled guilty and are presently in a federal prison.

In August of this year, a federal grand jury in Florida returned a 102-count indictment for twelve defendants, including two administrators from one of the nation;' largest home health care agencies and five physicians. It is alleged that this is a $15 million dollar fraud and one of the nation's largest home health care fraud indictments ever. Two of the defendants are charged with creating a large network of bogus nursing groups and then using these groups to fraudulently bill the Medicare system for home health care services that were not provided, or for persons, they knew were not qualified to receive the service. Those charged also allegedly instructed employees to fabricate the records necessary to support these billings and then "laundered" the proceeds through accounts set up through the hidden owners of the bogus nursing groups, who were either family members or friends of the defendants. The money laundering charges carry a maximum of twenty years in prison and a fine of twice the amount laundered. The conspiracy, false claims and wire fraud counts are punishable by up to five years imprisonment each and a $250,000 fine, per count. This indictment was a culmination of a four and one-half year investigation by the FBI and the United States Attorney's Office. The Internal Revenue Service was brought into this investigation in the latter stages to assist with the money laundering violations.

In this continuing investigation, last Friday, FBI agents in Miami arrested an additional five individuals including an owner of several home health groups, a physician, two nurses, and an attorney. These individuals were indicted on charges of conspiracy, false claims, kickbacks, wire fraud, money laundering, and obstruction.

For the record I would like to point out that indictments are not evidence of guilt. A defendant is entitled to a fair trial in which it will be the government's burden to prove guilt beyond a reasonable doubt. Also, I do not intend to imply that all home health agencies, the vast majority of whom provide a vital service to the medicare population, are involved in illegal fraudulent schemes.

In a highly unusual case, just a few weeks ago, two individuals were arrested and charged in connection with a two-year FBI sting operation addressing medicare fraud and money laundering. The FBI set up its own home health care agency and participated with the subjects in laundering $1.2 million in what the subjects thought was drug money through the subjects home health agency. The investigation is still ongoing and efforts are underway to freeze the subjects assets and prevent further medicare billings. The subjects home health agency received over $8 million in medicare payments over the last two years. The FBI is increasingly using the undercover technique and other sophisticated techniques to address complex health care cases and develop the best evidence as well as the scope of the problem.

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[1] Referenced Memorandum from June Gibbs Brown, Inspector General, to Bruce C. Vladeck, Administrator, Health Care Financing Administration, entitled "Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas," dated 7/28/97.

As the committee is aware, President Clinton and the Secretary of Health and Human Services recently announced a moratorium on new home health agencies while the Health Care Financing Administration (HCFA) implements the program safeguards included in the Balanced Budget Act (BBA) and develops additional changes that will strengthen the program and make it less susceptible to fraud and abuse. at this time I would like to comment on some of the key changes that are being made in the area of home health care. I will not attempt to comment on all of HCFA's planned changes, but only on those that most effect FBI investigations.

HCFA has announced that they are doubling the number of comprehensive home health agency audits that they will conduct each year. Common sense would lead us to conclude that additional scrutiny by auditors would lead to more fraud detection and consequently additional quality referrals for investigations by the FBI and the OIG.

Under new rules, HCFA will require home health agencies to re-enroll every three years and to provide an independent audit of its records at the time of its re-enrollment. The new anti-fraud measures also require providers to report their Social Security and employer identification numbers when making application for a provider number. Under the present system no unique identifying numbers are required when making application and an individual can have multiple provider numbers without the knowledge of HCFA. The simple variation of changing the middle initial makes any cross checking impossible. HCFA will also implement a requirement that home health agency owners furnish information about related businesses they own. This requirement to notify HCFA that an individual in fact owned related businesses may help alert auditors to potential cost reporting fraud schemes.

The Balanced Budget Act now requires that HCFA list a toll-free number on the Explanation of Medicare Benefits (EOMB) form to report suspected fraud and abuse. Hopefully, the publishing of this number will provide a vehicle for beneficiaries to alert the proper authorities to potential fraud. Lastly, the Medicare Summary Notice (MSN) is a great improvement over the current EOMB form and we would encourage its use beyond the few pilot states.

Despite the great strides made by the last two sessions of Congress, additional legal tools are still needed.

The FBI believes that there should be a liberalization of F.R.Cr.P. 6(e) to facilitate the sharing of information among criminal and civil attorneys in health care cases. Often, investigations which are initiated on complaints of criminal allegations fall short of the burden of proof required to sustain criminal convictions and the appropriate remedy becomes civil enforcement. Information currently obtained through the grand jury cannot be routinely used by civil attorneys, absent a court order.

Secondly, while section 204 of the Health Insurance Portability and Accountability Act (HIPAA) Act extends title 42 criminal provisions relating to kickbacks in all health plans receiving federal funds, except the Federal Employees Health Benefit Plan (FEHBP), it does not apply illegal remuneration prohibitions to the private health care industry. Congress has also not included a violation of the anti-kickback statute in the definition of federal health care offense. Thus, in an investigation based solely on illegal kickbacks, the new health care violations and new procedural tools, such as investigative demand authority and injunctive relief, will not be applicable.

Statistical analysis of billing data typically reflects high usage peaks during certain time periods for various procedure codes. Reimbursement for these procedures or tests require certification from a medical provider stating the procedure or test was medically necessary. Typically, after law enforcement activity is initiated, based partly on the statistically aberrant usage of a particular code, utilization decreases and another procedure exhibits higher than normal usage. When the medical judgement of providers becomes obscured by the motive for profit, all Americans seeking medical care become potential victims. The FBI and other department of justice components would support an amendment to the federal criminal code to create a new generalized offense against kickbacks paid in connection with a "health care benefit program as defined in 18 U.S.C. Sec. 24(b). This provision would fill the gap in the law by extending federal anti-kickback criminal sanctions to all health care benefit programs, public and private.

An ongoing FBI undercover investigation has determined that the payment of illegal kickbacks for referral of Medicare business is a widespread and accepted practice in the segment of health care under investigation. In addition to the FBI, the ongoing undercover investigation now involves investigators from the OIG-HHS, IRS, and DCIS. This investigation is but one example of the cooperative federal effort to combat health care fraud as directed in the guidelines of the health care fraud and abuse control program established by the attorney general and the secretary pursuant to HIPAA.

That concludes my prepared remarks and at this time I would be pleased to answers any questions that you may have.

Mr. BARTON. We thank you, Mr. Owens.

I want to compliment the witnesses. Everyone of you finished not only under 7 minutes, but under 5 minutes. That's pretty amazing.

The Chair is going to recognize himself for 10 minutes for the first rounds of questions. My first question is going to go to you, Ms. Brown.

This 40 percent number that came out on waste, fraud and abuse, some people have questioned, because that's based on a small sample size—that it may be wildly excessive. But just to put it in perspective, if 40 percent of my last vote in my last election, that'd be 80,000 votes. I mean, that's a huge number. Forty percent of $16 billion is almost $6.5 billion. You could run some State governments for an entire year on the fraud. So, is the 40 percent number a very solid number that you're willing to stand behind?

Ms. BROWN. Yes, this is a very tight sampling, with a 95 percent confidence level, plus or minus 2 percent, much more so than most samplings are. Mr. Grob, can give you more detail on how many were sampled.

Mr. BARTON. Well, please elaborate just a little bit, but we just want a base point that this isn't another government number; that you are very confident that there's that much fraud or abuse in the program.

Mr. GROB. It's rock-solid. We looked at more than 3,700 individual services, which is far more than we ever look at in many of the audits that we do. We did that because we had a stream of earlier audits that indicated a very severe problem. We knew that it would be controversial, and we wanted to be absolutely sure. The margin of error on this one is about 2 percentage points either way on that number of 40 percent and the same thing with regard to the money being spent.

The method that we used to collect the data was extraordinarily detailed. We didn't just look at records which is how the common audits are done, say in managing a program, but we actually went out and we interviewed the patients; we interviewed their family; we interviewed the physicians that authorized the services; we got the medical records of these patients; we combined all that evidence, turned it over to the intermediaries who are the experts in the insurance companies that run Medicare. We asked them to make the medical judgments. They did so based on the evidence that we had. They accompanied us on visits. There's nothing about the sample or the nature of evidence that in any way could be questioned here in terms of how solid this estimate is. It's a real serious problem.

Mr. KLINK. If the gentleman would yield one moment—I've just been reading the testimony of the people who are here on the third panel. I think that they're going to take—they're going to have a difference of opinion on this study—and I would ask that Mr. Grob or somebody who would be able to answer that might be able to remain in the room for the third panel. I think that would be helpful to the committee.

Mr. BARTON. Certainly. We can't command you to stay.

Mr. KLINK. Just ask for, if he could do that.

Mr. BARTON. Sure.

Mr. GROB. Be happy to do so.

Mr. BARTON. Now, one more point. You said in your written testimony that 25 percent of the home health care institutions that you looked at—presented 45 percent of the claims. So that—if you do the math—that could be that the other 75 percent of home health care are actually running a clean ship. Is that one conclusion that can be drawn from that statement or not?

Ms. BROWN. Yes, I think it could be. There are many, very good health care providers that are in this business, but those that are taking advantage of the business are billing a lot more than those who are providing legitimate services.

Mr. BARTON. So we should be able to come up with some criteria that would identify the potentially fraudulent, both institutions and in the claims that they're presenting?

Ms. BROWN. Yes, and that's what we tried to do. We identified them as what we called problem providers if they met a series of tests that were given that would show that their services were excessive or they were questioned in some way.

Mr. BARTON. Mr. Scanlon, I want to give you a chance to answer this same question. I'm told the GAO has got quite a bit of data too on the fraud and abuse in the system. Would you like to comment on what Mr. Grob or Ms. Brown said before we go to some other question?

Mr. SCANLON. The size of the effort that we undertook was not as large as that done by the Inspector General, however, we did look at a sample of claims submitted by agencies in California, to test the possibility of identifying problematic claims. What we discovered, using very simple criteria for selecting claims, simply looking at claims that involved large numbers of services, that we got a very high percentage of the claims that were not appropriate, in the range of 40 to 50 percent. I think it illustrates very strongly the payoff that may exist to a strategy to identify potentially abusive and fraudulent claims; that is, there are going to be high returns.

This is not, in our approach, and to an extent in the approach of the Inspector General, when we are targeting claims that we think—or agencies that we think—are problematic, we are going to get these high rates and we shouldn't interpret them as reflective of the industry and that's something that we've tried to distinguish. There is a difference between efforts to detect fraud and abuse and efforts to score or grade an entire industry.

Mr. BARTON. Well, I'm going to ask Mr. Owens a question, but just to put that again in perspective, we've watched with interest the stock market this week as it fell 500 points which was, I believe about 7 percent of the market and it came back yesterday, up 360 points.

Mr. COBURN. It's up 100 this morning, sir.

Mr. BARTON. It's up 100 this morning? Well, somebody's got more money in the market than I do then if you watch that on a daily basis like that.

But, can you imagine, if you called your broker and said, I want to buy 100—or 1,000—shares at $50 a share and they came back the next thing and said, oh well, it actually cost you 40 percent

more, it costs $75 a share. Or the other way, I want to sell. Oh, I'm sorry you told me to sell at $50, but we had a little problem and we're 40 percent off, so you're only getting $30. I mean, we'd come unglued. We just take this as something like, "Well, it's only the home health care component of Medicare, just 40 percent." I mean, it just boggles the mind.

Mr. Owens, you talked briefly about two recent operations in Florida, where apparently there was a national company that had a systematic effort to set up a scam, so this wasn't some little fly by-night, mom-and-pop operation. How many professional—either administrators, doctors, or nurses—were involved in those two operations?

Mr. OWENS. Let me just clarify your first statement. Mederi is a national home health care agency, but the two individuals that are charged in this indictment were administrators in Dade County, Florida, so Mederi itself is not implicated as a corporation.

Mr. BARTON. But they work for the national agency?

Mr. OWENS. Yes, that's correct. I can't give you those numbers. There were doctors, nurses, billing agents, as well, involved in this indictment of the 17 people. I can't give you those numbers specifically right now, but I can provide them.

[The information referred to follows:]

On August 7, 1997, a federal grand jury in Miami returned a 102-count indictment charging twelve defendants with a $15 million home health care fraud scam. Those indicted included the former Administrator of the home health agency, a former Assistant Administrator, a Physical Therapist, two owners and operators of home health nursing groups, two certified home health aides, and five physicians.

On August 22, 1997, additional indictments were returned in connection with this investigation. Those indicted included an owner of a clinic and several home health groups, a physician, an attorney, and three registered nurses.

Mr. BARTON. I mean, you're confident that this isn't just kind of, "Oh, we didn't realize you couldn't bill for that?" I mean, it's not just abusive in the sense they didn't know better? I mean there was premeditated, conscious effort to defraud the system?

Mr. OWENS. The indictment clearly charges a conspiracy among all the parties, yes, sir.

Mr. BARTON. Some of those indicted are medical doctors, M.D.'s?

Mr. OWENS. That's my—yes.

Mr. BARTON. Do you happen to know what the Florida Medical Society or the National Medical Society's position is and what steps, if any, they're taking to try to prevent their members from doing this? To me, the most respected pharmacists, doctors, nurses, to me are just a step below sainthood, because they're dedicated to saving lives and protecting lives and for them to engage in a systematic premeditated way seems to be beyond the pale.

Mr. OWENS. Well, in this particular case, the individuals are only charged at this point, but I know for a fact that our Miami office has been very aggressive in working with the State certifying agencies to try to deal with the medical providers.

Mr. BARTON. Well, my time has expired. I've got a whole series of questions I didn't get to on the prospective payment system, which is one proposed solution to the problem, and perhaps we can get to those later on.

The Chair would recognize Mr. Klink of Pennsylvania for 10 minutes.

Mr. KLINK. Thank you, Mr. Chairman.

Ms. Brown, in my opening statement, I talked about the fact that we've heard all these crazy stories about people operating out of the trunks of their cars and drug dealers being involved. What is the craziest thing that you've seen in your investigation of the home health care industry? Tell us, what's the worst case that you've heard of or the worst kinds of cases where people have—with no background or whatever circumstances—were able to get into the home health care industry and bill Medicare.

Ms. BROWN. One case that I thought would fall into that category, was a gentleman who, in prison, learned about the money that was available in this business of home health from fellow cellmate, I believe. He went out and set up a home health business, never once provided any kind of service, but started billing Medicare.

Mr. KLINK. From the prison or did he get out?

Ms. BROWN. No, once he was out—once he was out. Just a storefront, no services being provided. As he billed more, Medicare contacted him and put him on an interim payment system which pays you in advance so that you have cash—the devil made me do it; the money was so easy. It started coming in, even in advance, and he started manufacturing more cases in order to justify the money that was coming in, until he was finally caught. But that would certainly support one of our recommendations which is to do a much better screening.

The Balanced Budget Act gave us some further powers to do that kind of screening. For instance, people with a criminal record would not have to be admitted. Right now, we don't have—or we didn't have—the authority to keep somebody out simply because of that or past bankruptcies or other kinds of embezzlement schemes and things that would have shown that they were inappropriate. This man had absolutely no medical experience or training. We can now evaluate somebody's experience before admitting them to the program.

Mr. BARTON. So, did he use fraudulent social security numbers or were there real people and they did actually submit a claim?

Ms. BROWN. In some cases, it was real people, but in no case did he provide a service. He was getting social security numbers through various means. Once you get a person's claim number, you can start billing. It did come to light because of both dead people and people who weren't getting services. It could go a long way, and it did in that case.

Mr. KLINK. No, worst case for this fellow is he goes back to prison where he learns another easy scam from someone else——

Ms. BROWN. That's possible.

Mr. KLINK. [continuing] and we'll hold another hearing. We laugh, but this is very serious, what you've told us, Ms. Brown. How does a person like this get certification to be enrolled in a Medicare program? How does that occur in the beginning?

Ms. BROWN. This is why we proposed the moratorium, because HCFA is now setting up various powers granted to them by the Balanced Budget Act. They can screen these people for whether or not they have decent credit ratings, whether or not they've ever

been in bankruptcy, whether they have health experience and so on, which they weren't doing before.

Mr. KLINK. Doesn't the State, though—and I noticed that you picked on my friend's State, Texas, and you let us in Pennsylvania slide—but, don't the States have a level of responsibility to ensure that a provider has some kind of licensing? I see you nodding, Mr. Grob.

Mr. GROB. The system that has been used up to this time has primarily been through the certification system and it will be helpful, I think, in our discussions of this to make a distinction here between the certification system and the enrollment system. The certification system is the system that the State uses to determine that the applicant, to be a member of the program, has the capability to provide the health services for the business. So there are criteria related to that: Are enough nurses enrolled? Is the machinery there to provide the medical benefit, and does it look like that can be controlled. But up until this time, once a person got through that certification or quality of care kind of review, less attention was paid to their financial trustworthiness or their business backgrounds or their business trustworthiness. That's the element now that's being layered onto what the Health Care Finance Administration is calling the enrollment process. That's what's being strengthened now.

Mr. KLINK. Let me ask each of the witnesses this question because I—and I'll start with the IG's office. Is there a wide variation in the method in which these providers enter into the market, from State to State?

Mr. GROB. You know, I'm not really sure how wide it is. State's have their criteria and, of course, their criteria from the Medicare program as well. I think it really just depends on how many resources are available to both the State and the fiscal intermediary of HCFA to review the applicants. One of the things that was mentioned by Mr. Scanlon was the need to actually do things onsite. To get out there and do a thorough onsite review of the applicants. We believe that's what needs to be strengthened. I think there could be quite a bit of variation, because of the lack of ability to do onsite reviews to the depth needed to discover the capability of the applicant provider.

Mr. KLINK. Mr. Scanlon, is it more possible for a criminal such as this, or a drug dealer or somebody operating out of the trunk of their car, to get into this system from one State than another?

Mr. SCANLON. We haven't looked at that directly, but I think that it probably is. We find, in looking at the certification process, not just for home health agencies, but for other providers under Medicare, that the resources of the State surveyors are strained by their workload in terms of dealing with nursing facilities and home health agencies, and that very often the resources end up being more in the nursing facility side than on the home health side.

I think, from the Operation Restore Trust experience, that we saw that when State surveyors were both given additional training and there was a greater concentration on home health agencies, the certification was more rigorous; more problems were discovered. We have concerns about initial entry certification, which is something that HCFA is looking at now in terms of increasing the

rigor of that survey. Up to this point, it had been generally the case that if you served one patient, you could become a Medicare certified agency. It seems unacceptable that you have so little experience before you are actually certified and able to bill Medicare.

Mr. BARTON. What number should that be?

Mr. SCANLON. We think it should be at least 10. I mean, we recognize that these are often very small businesses that are starting up and that Medicare is the principal purchaser of this kind of a service, but you do need to have somewhat of a track record in terms of providing services. We're also concerned that the initial review only requires you to be able to provide one type of service at that point in time, and then you're certified and you're able to add additional types of services to those that you offer Medicare beneficiaries. We think that as you add additional services, those services—your capacity to perform those services—should be reviewed as well.

Mr. BARTON. Well, to be classified, I think, as a Medicare reimbursable for HMOs or PPOs, the number enrolled is several hundred, I think. It's a much larger number than 1 or 10.

Mr. SCANLON. Well, that's certainly true, but in terms of an HMO which is serving a much broader population, it's much easier to have a larger number of patients enrolled in your plan. Home health is still a relatively rare occurrence. I mean, even though we've had this tremendous growth, it's only 10 percent of the Medicare population that is using home health services, and so individual agencies are dealing with people that are at the extreme end of sort of the spectrum in terms of needing services. And so you have to keep the required number of patients before certification reasonable, given that this is a relatively rare need and that the businesses that we are often getting very good service from are small businesses, and we would be putting too great of a barrier in their way in terms of entering the system.

Mr. COBURN. Would the gentleman from Pennsylvania yield?

Mr. KLINK. I would yield to the gentleman.

Mr. COBURN. You know, I want to relate something that happened in my area. You get a home health agency that's certified and then all of a sudden they become certified and they're going to every nursing home doing bone densitometry studies on people who are bedfast, who are never going to get out of the bed, regardless of what it is, and then billing Medicare for that—never planning on treating the patients, just as a scam to collect more money. So, your question is very well directed. Once they get certified, then they're opened up for everything and they start doing it. So, it goes back to the point I was trying to make. It's design. The system, as we have it today, is designed to be defrauded.

Mr. KLINK. Let me change the question, Mr. Owens, for you. I still want to get down to the State to State, but I don't think we've determined at this point what we think home health care should be. It appears that there's really a range of expectations across the country as to what a home care provider should do or should not do. We can't seem to decide exactly, at this point, how large or how small they should be. The industry seems to cover a range of operators in both the size and the quality that they're offering. Do you see from law enforcement prospective, does this create a problem

for you when we haven't defined what we think that it ought to be, here on a Federal level, and you've got States, each kind of doing their own thing? Does that create a problem for law enforcement in cracking down on people who are operating fraudulently and fairly openly, according to the IG?

Mr. OWENS. I'm not sure I understand your question. I'm sorry.

Mr. KLINK. Well, there seem to be several standards depending on—as far as who can get in, if I'm listening to what the answers to previous questions were. From State to State, there seems to be a difference as to who can get in, who can't get in, who qualifies. You're Federal, so when you operate in one State versus another, if the standard for being certified and being a health provider in one State is different than it is in another State, if we haven't determined how large or how small you have to be, if you only have to be providing to one patient versus hundreds or thousands of patients, does that make it much more difficult to spot people who are operating fraudulently and are ripping off the system when you have, what may in fact, be 50 sets of standards by 50 different States?

Mr. OWENS. Well, it certainly might make certain States more attractive for people to go to set up these businesses, and from that standpoint it certainly is not a good way to operate.

Mr. BARTON. The gentleman's time has expired. If you want one or two additional questions after everybody's had an opportunity——

Mr. KLINK. That'll be fine.

Mr. COBURN. I'll be happy to yield some time to him if he'd like it right now.

Mr. BARTON. The Chair would recognize Mr. Coburn for 10 minutes and if he wishes to yield to Mr. Klink.

Mr. COBURN. He was kind enough to yield to me.

Mr. KLINK. I would just ask for 30 seconds, and I thank the gentleman for his courtesy.

I would ask Ms. Brown, what do you think, from a policy perspective, where do you think we need to head with this to make it more uniform on a national level where we're not playing under all these different sets of rules, where we can actually get a handle on who would qualify as a health provider? In other words, you've got this moratorium; what are we going to do with it?

Ms. BROWN. Okay, there are several things that are being done. We need to look at the trustworthiness of the business participants—in other words, is this someone that a bank would loan money to. You could do that by seeing whether they have large Federal debts from previous health businesses. Right now, those people aren't excluded. Bad credit ratings would be another thing or recent bankruptcies; their health care experience and training; the number of people they would have working for them; and their level of training. There are several things that could be done—whether or not they've had a criminal record in the past and whether it was something that would relate in any way to this particular business. Much more has to be done in the background checks of the people before they enter the program, and some of the new provisions under the Balanced Budget Act will allow for that.

The reason the moratorium was put in place and the reason we had recommended it was that now HCFA would have time to stop, knowing this very high rate of inadequate providers are coming into the program, to set up the mechanisms. They can argue about and discuss what would be best as far as the amount of experience, and so on, but at least they would establish some nationwide criteria for entering this program.

Mr. KLINK. I would yield back to Dr. Coburn, but in asking Dr. Coburn a question, because we haven't had a chance to ask this—do you think, Dr. Coburn, from your perspective, that we've determine what home health care should look like?

Mr. COBURN. No, and that's part of the problem. That's what I was going to ask you. Your idea of a physical exam before signing is a great idea. We passed a part of the insurance reform bill, the Kassebaum-Kennedy Reform bill, that physicians were money-damage liable if they signed for it. Those regulations haven't come from the administration. I've written two letters to the administration asking them when they're going to come. HCFA hadn't put them out. Well, if we start allowing—and as a physician, I hated to put forth that bill, but that's something that we're going to have to do, and it's the wrong way to fix the problem, I agree.

I want to ask you, Ms. Brown, now that you've seen this study—and maybe you can answer this, maybe you can't—is it not true that we really need to change the system more than to change the little caveats that you're suggesting, like looking at the people, what their past history has been, because, look, I can game that. I'll put somebody in business. If you're an easy ripoff, I'll put somebody in business with their name, with their corporate ID number, with their background and I'll control them and I'll still rip you off if the system's still easy to ripoff. The other question that I wanted to ask you is what percentage of our home health care is for chronic illness and what's prospective payment going to do for the poor people out there who are most dependent on home health? And those are the people that are home confined that have a chronic illness that don't have anything to do with hospital stays and that's where most of it's going. So how is prospective payment going to change that?

Ms. BROWN. One thing we have found is the number of visits in what we have identified as problem providers. They have a much larger number of visits for a particular episode or a particular condition than would other home health providers who seem to be operating in an ethical way. So, the new payment system will allow a certain cost for covering whatever is done, and it will take away the temptation to provide a lot of additional visits or services beyond what was really necessary.

Mr. COBURN. But the risk of that is to take away care from those that are elderly and chronic, which we really want to help. What's going to happen, if you have a home health care firm, and you have this person out here that has a chronic disease and you get a fixed amount for it, and you have these that are turn over, where you going to spend your efforts? You're going to spend your efforts on the short term. The people with chronic disease are going to get short changed by what Congress has done with the prospective payment system, as I see it.

Mr. GROB. If I could address some of your concerns?

Mr. COBURN. Go ahead.

Mr. GROB. What we found in our studies was a shift. Originally, the home health program was for the person who had a prior hospitalization experience; and, in that case, it was much less problematic because it was an acute need that was fairly well defined to recover from the visit to the hospital.

Mr. COBURN. So, what you're saying is when Medicare home health was started, that's what it was started for——

Mr. GROB. Exactly.

Mr. COBURN. [continuing] and that's what it was designed for, acute post-hospital care.

Mr. GROB. Exactly.

Mr. COBURN. And what is Medicare home health now?

Mr. GROB. It is used much more for chronic care; and, by the way, that is where we are finding the multiplication of visits lie. When we began to look at the variation in the number of visits that were being provided to the patients of particular home health agencies, we saw that the greatest number of visits were being provided to the people who had chronic conditions. These were patients who were not associated with a prior hospitalization visit. What we found is that those visits were much more for the home health aide visit, which is also authorized under the home health care if you do need skilled care. It wouldn't be authorized by themselves, but if you need skilled care at all, then you're also able to get the home health aide visits. We saw the great expansion of visits on the home health aide. That's a fairly easy thing to generate a document that says that someone needs a home health aide visit.

Now, we believe that the prospective payment system, if designed properly, can well address this problem.

Mr. BARTON. Excuse me, it's easy to generate what kind of a document?

Mr. GROB. If you want to generate a claim for a home health aide visit.

Mr. BARTON. Home health "A"——

Mr. GROB. Aide visit.

Mr. BARTON. Aide. A-I-D-E.

Mr. GROB. Yes, A-I-D-E. Let me explain that to be eligible for the home health program, one of the requirements is that you need skilled care. That could be the care of a skilled nurse. It could be therapy, for example. Once you need that skilled care, you are also eligible for more routine visits by home health aides which is not regarded as a skilled care.

Mr. BARTON. Okay.

Mr. GROB. If you don't need the skilled care, you're not eligible for the latter. But, once you're in, then you are eligible for the others, and it is fairly easy for a company to keep sending nurses out. I remember one time giving a speech on this. Afterwards, I was sort of ganged by a lot of people from the industry. Some said, "You know, it used to be we would do 30 visits a year. Now, some of my new competitors—brand new—are doing, you know, 80, 90, 100 visits a year, and we're just really not sure all that is so needed. What you're saying is really true, that this is expanding in an area that's very difficult to control."

I think Mr. Coburn is saying, you know you could argue a lot with someone as to whether or not they need that one additional home visit. It's very hard to define.

Mr. COBURN. But there's a big difference between whether we pay $55 out of Medicare for a home visit for an aide to help clean a house, versus paying $12 through the provider system of the State Medicaid system which we've told the Governor "don't worry about it, we'll pick it up in Medicare." So, you know what they've all done? They've canceled the provider programs coming through Medicaid. Guess what, more money for the State, because Medicare is going to pay it. So, my whole point in asking the question is that we've got a system that's designed for the program. Therefore, it's not any wonder that, in fact, we're not getting value. That's not to say we don't have great people out there, doing great work for some of our seniors, but we're not getting value for the dollar and we're at the point where we're going to fix the wrong problem again. We're going to follow your recommendations and tweak it here and we're going to probably follow FBI——

Mr. BARTON. Dr. Coburn, you're obviously the most knowledgeable member of the panel, but won't the PPS, the prospective payment system, solve or at least go a long way toward solving the problem the problem you're addressing?

Mr. COBURN. First of all, the first thing it's going to do is shift care away from those people that need it the most—the poor and the elderly, because—do you think they're not going to crank down the numbers on that? So, the home health care agencies that don't have a conscience, they're going to go for the short term where there's going to be a defined amount of money and a short term number of cares and you're gone and they're not going to use the outliers that are available in other Medicare because there's not going to be the money to be made there. So the people who need home health care the most in this country are people that are going to least likely get it through the prospective payment system that's getting ready to happen.

A lot of people don't believe that, but when we're back here 2 years from now asking you whether they're getting it, you're going to find that the greed that we have created and allowed to fuel itself in this system is going to be the very greed that keeps the seniors that need home health care the most from getting it.

Mr. Scanlon?

Mr. SCANLON. Dr. Coburn, I share your concerns about the prospective payment system because I think you've identified quite precisely the kinds of incentives that can be created, but I also think that it's possible within the design of this system to try and counteract some of those incentives. We've seen in the case of State Medicaid programs in the nursing home area where they recognize differences in care needs and pay accordingly, that it actually is the heavier care patient that has the best access to care.

Mr. COBURN. But that's in a State Medicaid program.

Mr. SCANLON. That's in a State Medicaid program. We need to think about something similar in Medicare. The second thing——

Mr. COBURN. And that's not set up now?

Mr. SCANLON. No, it's not, but it needs to be. The second thing is that prospective payment alone is not going to be the answer.

Prospective payment creates a set of incentives that are potentially going to lead to sort of harmful situations. You have to have the mechanisms to identify those and prevent them. You have to be able to say this person is not eligible for a home health benefit, we're not going to give you any payment. You also have to be able to tell an agency, you're not providing enough services to individuals and those are key in our mind.

Mr. COBURN. So there's some key components? We have to look at who should be eligible for Medicare home health. The politicians in this town are afraid to touch that. They're afraid they might not get a senior's vote for fixing Medicare home health by saying that maybe everybody that's getting home health right now doesn't deserve it and doesn't need it, and maybe we can supply some needs for those people who have needs that aren't Medicare needs—needs for somebody to come in, and visit with them which is a lot of what happens, somebody to help give them a bath. I mean, when is giving a bath health care? A charge to the Medicare account that everybody that's working in this country is paying in for. I'm not saying it's not a need. We need to develop that and maybe what we need is a new system that takes maintenance of our seniors outside of the Medicare program where we can help them. Because I'm convinced that's where the majority of the money's going and that's where the majority of the margin is for a lot of home health firms that are bilking the system.

I want to ask one other question and it's for Mr. Owens. Recently, the FBI did a complete investigation on a large multi-office home health care firm in my district at our urging because of the claims that were brought to my office. It was not prosecuted, and one of the reasons they didn't prosecute it was because Mr. Stupak's bill isn't law. Is it the FBI didn't have the tools, even though they knew there was fraud there, they knew the intent was there to defraud, they could not prosecute these people. These are people that bought their car for their home, the computer for their home, the television for their home, the copier for their home. They had it in the business, too. Medicare paid for all of that. I mean, this is not simple, questionable fraud. This is direct fraud that they could not prosecute because they couldn't get a U.S. attorney to prosecute because the laws are not such that they can carry that kind of information into a courtroom and know that they are going to get a conviction.

So, one of the things we need to do and I know Mr. Stupak will do, is bring out, what do we need to change for the FBI to be able to prosecute people when they're defrauding this system?

I yield back.

Mr. BARTON. Thank you, Dr. Coburn. We ought to put you out there on the panel so we could ask you questions.

Mr. COBURN. I would love to be out there.

Mr. KLINK. Unanimous consent is given.

Mr. BARTON. We'd recognize Congressman Stupak of Michigan for 10 minutes.

Mr. STUPAK. Well, thank you, Mr. Chairman, and I thank my friend, Dr. Coburn, for the segue into my questions.

Part of my opening was my amendment that I've been pushing for the last year and, if I understand correctly, what you're saying

is the shift you saw in the increased cost to Medicare was what the system was designed for was to help those who need clinical care in their home, but now there's these added on with the aides? By aides, I mean the workers doing like dieticians and things like that; that's where the increase in the study you indicated to us, right?

Ms. BROWN. The greatest.

Mr. STUPAK. Greatest cost and the greatest problems. So then which leads to the questions, then in order to effectively combat this fraud, waste and abuse, such extensions of subpoena power, injunctive authority, liability of physicians in specialty hospitals and expansion of criminal penalties for kickbacks, that legislation then would make sense to help at least direct some resources at this problem you've identified?

Ms. BROWN. Yes, all of those tools, of course, would be very helpful.

Mr. STUPAK. Okay. Now, even though you have all the tools, whether you're at the State or the 104th Congress and even the 105th Congress, Congress I think shares some responsibility here, because we continually cut your budgets and whether you're trying to do this new certification problem or proposal or trying to do criminal backgrounds, whatever the case may be, you need the resources, at least administratively, to do your job. How much cut has there been in the office of Inspector General in this area in the past few years?

Ms. BROWN. Our office had been cut severely, but as of the Kennedy-Kassebaum legislation, there was additional funding provided for the office, and we're now building. It's a 7-year program—we're now entering the second year in which our office is growing.

Mr. STUPAK. Well, is this from the fraud control account that we've tried to do some work in? I know, Mr. Dingell and I had a bill two Congresses ago to try to put 10 percent of the savings back in there, so you can go after this.

Ms. BROWN. I guess the Congress wanted to avoid it being a bounty system, so they didn't make it an actual percent; but they did give solid funding from the trust fund because of the large amount of money that we were returning to the Federal Government. They also started putting all of these recoveries back into the trust fund rather than the general treasury. So now it's very visible, the amount of money that's being saved for the trust fund based on the work that's done.

Mr. STUPAK. We mentioned that this Congress has cut back resources to your efforts and Dr. Coburn rightfully pointed out the Medicaid system. Have the States done the same thing? Cut back in the enforcement area?

Ms. BROWN. Well——

Mr. STUPAK. By cutback, I mean just financial support of it. I mean, you can't do this stuff unless you have people there doing it.

Ms. BROWN. I'm most familiar with the Medicaid area and the Medicaid fraud control units which we, the Federal Government, administer the grants to each State, and we pay 90 percent for the first 3 years and then 75 percent after that. I know from the feedback I get from the Medicaid fraud control units that money is

very, very tight at the State level and, in fact, sometimes they can't use all the money that's available, by our paying 75 percent, simply because the States can't come up with the 25 percent to match that and increase their capability of looking at Medicaid fraud.

Mr. STUPAK. You've indicated, that the certifications is one are you're going to be in. We have the prospective payment system, which will make us more proactive. In law enforcement, unfortunately, we're always reactive, and even my amendment, with subpoena power and injunctive authority, that's still reactive. What else can we do, or what other changes can be proposed to make us more proactive in trying to get at this 40 percent waste that you cited? What else can we do besides prospective payments and the certification?

Ms. BROWN. One of the biggest things I think is to look at the bankruptcy laws. The most flagrant abusers use those bankruptcy protection laws, not as intended to help somebody who is in over their head at an honest attempt at business; but instead, they immediately file bankruptcy when we come in, to eliminate all the claims that the Federal Government has coming back to it. And also, HCFA cannot suspend their payments, so they continue to get paid.

One company that we had a case against were getting $27 million every 2 weeks in prospective payment. When we did go in and establish that there was fraudulent activity going on and that they were flagrantly abusing the system, because of the bankruptcy protection, HCFA was not able to stop making those payments, even during the time it took for us to get the indictments and eventually convictions where both the husband and wife are now serving time in prison. This was an organization where Medicare was paying for personal airplane flights. They had a BMW that their son used in college that was supposed to be a delivery truck or supply van; all kinds of gifts that they were giving; the cable TV for their home and that of their mother were all charged to Medicare. A lot of things that, you know, any citizen could see, was flagrant abuse of the system.

Mr. STUPAK. But it appears that we always have to wait until there's a long history of abuse and a pattern of it before we can do anything. I guess I'm trying to say, how do we prevent it before we get there, other than certification? What can we do? Obviously, the subpoena power and injunction authority that I propose may be——

Mr. COBURN. Would the gentleman yield?

Mr. STUPAK. I'd be happy to yield.

Mr. COBURN. Would changing the definition of homebound help change the fraud component?

Ms. BROWN. I think it would be a great clarification that would be very helpful to all concerned along the line, to make a very clear definition of homebound. Any of these factors that are not clearly defined by HCFA always cause great problems, not only in allowing a lot of the abuse to occur, but then to get any kind of a conviction once somebody has obviously abused the system, because they can use that as a way out.

Mr. STUPAK. Well, Dr. Coburn had an amendment when we were doing the reconciliation bill about homebound. Have you seen that

amendment? I mean, have you seen some of that? Is that a step in the right direction?

Mr. GROB. In the deliberations on that, the Congress decided that it wasn't so clear and so they commissioned a study to come up with recommendations to clarify the definition.

Mr. STUPAK. When is that study going to be completed?

Mr. GROB. It was 1 year.

Mr. STUPAK. See, we're still reacting. We're not being proactive here.

Mr. COBURN. Anytime we don't want to do anything, we do a commission to study it.

Mr. STUPAK. Is there some things we can do with that definition that would help us in this area of homebound?

Ms. BROWN. Certainly, the clarification would be very, very helpful. I think Dr. Coburn has been very wise in some of his recommendations. He certainly sees this problem as we do.

Mr. STUPAK. He's gotten much wiser since he's endorsed my legislation. I agree with that.

Mr. COBURN. With changes.

Mr. STUPAK. Thank you. I yield back my time.

Mr. BARTON. I think Mr. Scanlon wanted to comment.

Mr. SCANLON. I just wanted to note that, in addition to the clarification, we really think that the application of this definition, as well as the other standards, are key aspects. It's not so much that we don't have a set of conditions for participation and that we don't have a definition of homeboundness, even though it could be improved; the issue in part is that we do not apply it sufficiently and part of the reason is that we don't have the resources to do that, but that can't be our only excuse. We need to figure out how to better use the resources that we have in a targeted way so that we create the deterrent effect. I mean, you've talked about criminal activities. A proactive stance is to have a strong enough presence that you are a deterrence and I think we have had such a weak presence that there is no deterrence today.

Mr. STUPAK. Well, I certainly will agree with you. I think you have to do a definition and then you have to have the law enforcement tools to do it, and then you have to have the resources to give to law enforcement and the rest of it to carry it through. I doesn't do us any good to attack the definition if we're not doing the law enforcement. I doesn't do us any good to do law enforcement when we don't have the resources to back it up.

Mr. COBURN. The problem with the definition is right now is there isn't a senior in this country that I can't qualify by writing a plan of care for in their medical history to get them home health and do it legally. That's what the problem is with the definition. I can get anybody on home health care if I want to, and if I'm a little bit sneaky, I can get Medicare billed $50,000 or $60,000 a year on it, and I can do it within the law. That's the problem. That's how broken this system is. You see doctors every day wondering, "Should I sign this? I know she needs some care, but, boy, she doesn't need a nurse going there? She needs somebody helping her. Well, I'll sign it."

Well, look what kind of a bind we're putting physicians in this country to try to help. We're making them lie to help their patients.

It's the worst of all worlds and at the same time we're saying 40 percent of it's fraud. We need to change the system.

I would suggest, Mr. Chairman, that our committee staff review what was said when Medicare home health was started, because if you go back, you see a very clear purpose of what it was intended to be and this is not what it was intended to be when it was created.

Mr. BARTON. Of course, if it's done correctly, home health care can lower costs. I mean it is——

Mr. COBURN. Not the way it's being done today.

Mr. BARTON. I said if it's done correctly. I'm not saying it has been done correctly.

Mr. KLINK. If the gentleman would yield—we're kind of having a free-form discussion here.

Mr. BARTON. Well, we've got Mr. Engel here, whose been very patient, but we'll let Mr. Klink ask his question.

Mr. KLINK. Just 1 second, because I just—Dr. Coburn made the point, and I would have to agree with him, that when you get to the prospective payment system, the question is whether or not you have locked out people who legitimately need home health care. But in getting—first of all, I'm not convinced that we're ever going to get there by 1999. We've seen problems to get these matters—in getting these costs and billings for Medicare under control and in fact, we had a whole hearing on it where we had a computer system that we still don't know what we got for the money that we put into it. But in the meantime, we're into an interim payment system, which really seems to offer more opportunities for fraud and abuse, and I just wondered if either Dr. Coburn or the witnesses had an opinion about it.

Mr. BARTON. And then we have Mr. Engel patiently waiting at the end of the dais.

Mr. ENGEL. I have an opinion about it.

Mr. BARTON. We'll give the panel an opportunity to answer Congressman Klink's question.

Mr. GROB. We really agree that the prospective payment does hold forth good promise to get a control on the program subject to the detail design work that's been called for here to really address these problems. It's a hard task, and our greatest concern is what will happen in the meantime. Now, fortunately, some of what was done in the Balanced Budget Act will help; there are some interim limits on costs and on price. These, in effect, will have a tendency to put reasonable, limits on utilization based on past experience with these patients. It'll help utilization from exploding even further.

So, I think that some of the interim measures will help, but they're far from perfect; so we're back to the question of timeliness. And we think that timeliness is very important because, until it's set, we're going to just continue to see that money float out there.

Mr. BARTON. The Chair wants to make an announcement. There is a pending markup in the Telecommunications Subcommittee downstairs. Members of that subcommittee are Mr. Klink, Mr. Engel and myself. So there is a probability in the next 20 minutes we'll have to go cast at least one, perhaps two—roll call votes. If that occurs, we will continue the hearing and Dr. Coburn will

Chair it and Mr. Stupak will assume the position of the ranking member on the minority side.

Mr. Engel is recognized for 10 minutes.

Mr. ENGEL. Thank you very much, Mr. Chairman, and I want to commend you for holding this very important hearing. The panel, of course, you've heard the frustration which we all share, and when we go back to our home districts and speak with seniors, they tell us horror stories, and with my mother in Florida, she tells me stories. Many seniors are convinced that if we could just clean up the fraud and abuse, they wouldn't have to endure any kinds of cuts at all in Medicare; then they could save the money without absorbing the cuts in services.

I'm a strong supporter of home health care. I believe in the concept. I think that Dr. Coburn and the chairman are quite right that, if you're doing it correctly, costs should be lower. Cost should be lowered; people are feeling much better if they can get health care in their own homes, because they don't have to leave their homes. I think it's therapeutic. So, it's really a win-win situation if it's done properly.

In New York, there are generally more restrictions. I think the program is a little tighter; there are more regulations. So, I think that we—while we've had some difficulties—haven't perhaps had the difficulties that some of the other States that are more unregulated have had. I'm wondering, can anybody speak on that?

Mr. GROB. This actually goes back to a question which Mr. Klink had asked earlier. There are differences in the intake process within the States, and it's true that New York State does have a stronger certificate of need program than some other States do have, but I can't tell you from the studies we've done—especially the more recent ones—to be able to compare the error rates. People, in fact, have asked us that question. The survey that we did is very sensitive in terms of the overall error rate, but it's not sensitive enough to measure the differences in the error rate among the various States.

I think that sharing of effective practices is a very good thing to do and HCFA is well positioned to solicit those ideas from the community of providers. As far as conducting the studies, the rules of statistics would require, for example, that you would do in New York, say just to give an example, samples of the same size that we need to do for the larger group. In other words, the sampling rules are wherever you want to measure that difference, you have to draw the sample from the universe you're measuring. So, if we tried to compare every State, we'd have to conduct in every State a study that's as broad as the one that we did in the four State area.

Mr. KLINK. Would the gentleman yield for a moment?

Mr. ENGEL. Certainly.

Mr. KLINK. I'm stricken by one comment. If New York has a stronger certificate of need and is doing a much better job than other States and you've got a four State study that includes New York that shows 40 percent of the payments were improperly paid. If we don't include a State like New York that has a strong certificate of need and is doing a good job, then that 40 percent figure—

if we would have chosen States randomly that do a worse job, that 40 percent figure would be a floor, not a ceiling.

Mr. COBURN. If Mr. Engel would yield just for a second?

Mr. ENGEL. Certainly.

Mr. COBURN. You don't have data at the Inspector General's Office that says New York is better and I don't want us to leave that, because that's an assumption that I don't think is necessarily true.

Mr. GROB. That's what I was trying to clarify, that we don't have the data that actually shows the differences in the States.

Mr. KLINK. All right.

Mr. ENGEL. Well, let me talk about the 40 percent. Can you clarify for me the criteria that was used to come up with the 40 percent figure? Were the claims that were used to review the matter randomly selected or was there a process used to target those agencies that are more abusive of the system?

Mr. GROB. That particular study was randomly selected, and it was intended to be projectable to the universe of the four States. It's not necessarily projectable to the whole of the United States, but to the four States that were the universe of the study. It was designed to be projectable to that universe. So first, we used a two-tiered sampling technique. First, randomly selecting 250 claims and then looking at all the services, of which there were 3,700, within those claims. So, those were completely randomly selected. As far as the review is concerned, when it came to the reviews of medical necessity and homeboundedness, which were where we found the majority of the error, those determinations were made by the medical experts from the intermediaries who are responsible for processing the claims in the Medicare program.

We wanted to mimic the process that was used there, because they're the ones who are the experts on the medical review. We gathered the evidence for them in terms of the medical records. When we visited the patients, those reviewers often accompanied our auditors to visit the patients and take down information about their condition. So, it was projectable from a statistical point of view, and from the point of view, of gathering evidence, we used the best experts we could find and tried to do as thorough a job as we could in gathering the raw data for it.

Mr. BARTON. If the gentleman would yield before we get off that point? The very fact that you did this sampling technique on as large a universe as you did, indicates—especially if you consider those four States probably have 20 percent of the population in this country, maybe more than that—Texas alone is, I think, 8 percent of the population—so, while they're not exactly replicable around the country, order of magnitude, they're not going to be off much. I mean, they're not off 40 percent, compared to Utah, for example.

Mr. GROB. We did—if you would throw Florida in that mix, you know, one more, then you've got about 40 to 45 percent of Medicare expenditures for home health in this country. We've got to hold back and say it's 40 percent with statistical precision. But in another study, we compared the characteristics of the programs in those four States with the characteristics in the other States in terms of who is eligible, what is the patient mix like, what is the average expenditure; and basically, those States were simply interspersed through all of the others, so in essence they sure look alike.

Mr. BARTON. You can't say there's some State that's only got 10 percent fraud and there's some State that's 80 percent. The probability is every State is between 35 and 45 percent based on your sample.

Mr. GROB. Certainly, pretty high. Certainly, it's going to be in that range. It's going to be—I don't want to name a number, because then you won't be able to trust me the next time I make a statement.

Mr. BARTON. I'm sorry, Mr. Grob.

Mr. GROB. But it's in that ballpark.

Mr. BARTON. Alright.

Mr. ENGEL. I want to just beam in on the 40 percent. Are you saying that 100 percent—how much of the 40 percent is actually attributed to fraud and abuse? Would you say almost all of it?

Mr. GROB. Well, what we are saying here is that these claims were improperly paid. Okay, that is for the patients here, the bill should not have been paid, given the criteria for a medical necessity for homeboundedness for physician certification.

One of the problems we have is distinguishing the difference between waste, fraud, and abuse. Okay. Fraud is where someone quite deliberately breaks—decides to break—the law. This 40 percent figure could range all the way to an accidental error that someone might make by submitting a bill that, you know, shouldn't have been submitted. So we have to look at it across the board in terms of whether the payment should have been made.

So we looked at it more as a control system. Does the Health Care Financing Administration's control system have the ability to determine whether the payment should be made or not? In other words, is it making the payments? But I can't tell you how much of that was outright fraud; how much of it was what we would call abuse, which is where people are exploiting the program—either within the limits of the law or on the fringes of the law—in such a way that you would never be able to prove it; or how much was an innocent error.

Mr. ENGEL. What's your gut? What's your gut? I mean, is it a substantial amount?

Mr. GROB. My gut is that the substantial amount of it is, what I would call, the exploitation or abuse of the benefit—multiplying benefits, unnecessarily sort of shaving, you know, basically taking the program for as much as you can get from it.

Mr. ENGEL. Let me yield to Mr. Stupak on that point.

Mr. STUPAK. Whether the fraud, waste, or abuse—whatever label you want to give it—whether it's by accident or intentional, it still cost the taxpayers, from a financial point of view?

Mr. GROB. That's exactly right.

Mr. STUPAK. The only difference would really come in if you're going to do a criminal-type prosecution.

Mr. GROB. Yes, and the problem is those are much more difficult to prove. And so, you get back to the business that if you were to rely on law enforcement, you'd never really be able to shut down all the problems. You do have to get back to program design to remove the incentives and establish the controls.

Mr. STUPAK. Thank you. And thank you for yielding.

Mr. BARTON. I'm sorry, you still have time on the clock.

Mr. ENGEL. I was going to ask: to what extent do you think the level of fraud and abuse found in the investigations exist in the industry at large? Is this pervasive throughout the industry, or is there a small core of bad apples taking advantage? What's your feeling about that?

Mr. GROB. Well, that's why we did the study on the problem providers. Now again, we can't prove that those people broke the law. In fact, many of them may not in fact have broken the law but in different ways were exploiting or abusing the system. And there, what we found, is by using criteria to measure providers who might be exploiting the program in that way as detected by the intermediaries who are running the program, and being pretty conservative about that, we determined that 25 percent of the providers would satisfy that definition of a problem provider—a provider to watch, if you will. Twenty-five percent in a five-State case, and they got 45 percent of the money.

Mr. BARTON. The gentleman's time has expired.

We have a vote on the floor.

That concludes the first formal round. We're going to let Dr. Coburn ask one question, I think. Congressman Klink may have one question. If we have time, I'll have one question. Then, we'll excuse this panel and we'll reconvene the second panel at 12:30. We're going to take a little 30 minute break here, while we go vote here and come back. But, I think Dr. Coburn had one final question?

Mr. COBURN. I'd just like each of you to answer yes or no to this question. If we redesigned the Medicare home health program, where it was designed to take care of those people who had to be at home, who truly had a need, and designed it in such that if you were a reputable firm you could make a good return on your investment, wouldn't it be good for the good firms that are out there now? And wouldn't it eliminate this 25 percent of the problem ones, because a good portion of them really don't care about helping people, what they care about is taking money out of the tax payers bank account? Wouldn't that be helpful if we redesigned it defining what homebound is, defining very carefully what specific benefits? Wouldn't that help the reputable home health firms that are out there now and the visiting nurse associations that do such a good job?

Ms. BROWN. My yes or no is yes. And, in fact, many of the complaints we got were from these reputable firms who said they can no longer compete——

Mr. COBURN. Right.

Ms. BROWN. [continuing] if people were providing excessive services, and they couldn't compete on an ethical basis.

Mr. SCANLON. My answer is yes, too. And, in our 1996 report, we indicated that that is something that the Congress should consider because it is the Congress' prerogative to decide what benefits to give out.

Mr. OWENS. I agree, Dr. Coburn.

Mr. COBURN. Thank you.

Mr. BARTON. Congressman Klink?

Mr. KLINK. Yes, a very quick question, Mr. Scanlon. Is there any way possible, in the opinion of you at the GAO, that HCFA can get to PPS by 1999?

Mr. SCANLON. We think it's an incredible challenge. This is not an idea that's just come up recently. I mean, HCFA has been working on the issue with respect to payment for home health for years, and while there's a lot of progress that's been made, we think there's a lot left to be done. It's a question that I hope you will ask of HCFA, and we will be working to monitor what they do; we have some doubts, but we hope that those doubts will be unfounded.

Mr. KLINK. Well, if we had the political will to impose a co-payment immediately, would that help in the interim while we're getting to PPS?

Mr. SCANLON. A co-payment may have an impact upon utilization, but it may not be as great as we might expect because of all of the beneficiaries that have some form of third-party payment, either through Medigap policies or Medicaid to cover their co-payment. So, it's an issue that will, undoubtedly, have an affect, but how big of an affect is not clear.

One of the things that's still challenging in the Balanced Budget Act, but is a part of the interim system, are the normative guidelines in terms of what services should be received, and services beyond that level can be easily denied. That's a challenging task to develop those normative guidelines. We have this bad data that I talked about that are the bases for understanding what services have been received, and it's very difficult to use those data to develop guidelines.

Mr. KLINK. How do we hold HCFA's feet to the fire in this instance to really cause them to do this? In other words, should we set milestones, or——

Mr. SCANLON. I would hope that they are already in the process of setting milestones. I think that you need to be aware of what those milestones are, and that you also need to ask them to respond to you if those milestones can't be reached, and what the contingency plans are for accommodating—or reaching an ultimate goal—if the milestones are not going to be reached.

Mr. KLINK. Thanks, Mr. Scanlon.

Mr. BARTON. My final question is for Inspector General Brown. Now, you have recommended this moratorium up front, in writing, at least since May 1997. So whether it's a good idea or bad idea, your office has been very up-front that you wanted this moratorium on new agencies—new home health care providers. However, you're about the only one that's been up-front about it. Now, our next testifier from HCFA has been for and against it depending on which way the wind was blowing, when that wind was blowing, and who was blowing the wind.

So, my first question is: what is your basis, and do you have any information why HCFA rejected the initial recommendation of your office to impose this moratorium?

Ms. BROWN. I can only say that this is a drastic measure. We felt, once we knew the quality of the report that we had done and the shocking statistic that 40 percent of the payments should not have been made, we felt that this was so extreme a problem that some kind of really drastic action had to be taken. And, I think,

when the first draft report was read, that perhaps that impact hadn't hit yet. You know, all of the fixes are going to take time, even with the new authorities given by Congress, and we felt a moratorium was a very good way of stopping this outpouring of funds, or at least slowing it down until some of these fixes could be put in place.

Mr. COBURN. Mr. Chairman? Could I just pose one question?

She had made—Mrs. Brown had made—a recommendation that physicians do a physical exam on the patients. I wonder if that will be in the physician's office? And if so, do they then qualify for being homebound if they can come for that initial screening examination?

Ms. BROWN. Well, of course, there's a lot to be worked out. Some of these would be in the hospital because patients are being discharged from the hospital, and those who are homebound are being seen by a physician.

Mr. COBURN. But that's not where we've really seen the abuse is post-hospital right now? Right?

Ms. BROWN. That's not the greater place.

Mr. BARTON. Now, I want to be sure before I conclude, when you recommended the moratorium, HCFA did reject that.

Ms. BROWN. Yes; they first rejected that.

Mr. BARTON. Okay. When, to your knowledge, did they then change their position?

Ms. BROWN. I think George might have the dates, but there were a number of meetings that were held where they looked at all different options. We had given them a whole list of options—not necessarily all things that should be implemented—but that was one of many options on which we said some actions had to be taken because this was such an astounding number. And they were reviewing each of these options. And, I think, that during that review, they recognized that most of them would take quite a bit of time, and they eventually came back to the moratorium.

Mr. BARTON. Now, when staff tried to work with staff at HCFA to pin this down, we were eventually told, again at the staff level, that Secretary Shalala recommended and made a personal phone call to the President of the United States recommending this moratorium. When Secretary Shalala was asked that question directly, again at the staff level, I'm told that she said that she never made a phone call. And that meant that the written testimony that HCFA had submitted to this subcommittee was fraudulent. Because, they said in their draft initial testimony that the reason that the moratorium was imposed was a direct request in a phone conversation from Secretary Shalala to the President. They since recanted that. Are you aware of any written documentation from HHS, other than yours, where Secretary Shalala was recommending to the White House that this moratorium be imposed? We've not seen it.

Ms. BROWN. I've not, personally. Do you have any?

Mr. GROB. I'm going to try to remember. There were so many discussions about this, and we certainly became aware that the administration had chosen the recommendation that we had made shortly before it was announced. We had been involved in the sense that we were being asked many questions about—similar to the questions here—the nature of the rationale for it, the strength of

the evidence, the various ideas that we had. We participated in that. And, you know, there were different correspondences and typical staff work was being done. So, I'm not trying to avoid answering the question, my memory just isn't good enough right now to remember if there was a particular one.

Mr. BARTON. Well, we don't want to strain the memory.

Mr. GROB. Right.

Mr. BARTON. Because there was a bipartisan agreement that we need to get to the bottom and try to work proactively in a positive way with HCFA and HHS to solve these problems.

Mr. GROB. Right.

Mr. BARTON. But we have to have credibility. You have to have trust. And, it does bother myself as chairman, and I think bothers the ranking member too, that some of the written testimony as initially submitted was flat in error.

We're going to recess the hearing until approximately 12:30, when we will hear from the representative from HCFA. So, we're in recess to approximately 12:30.

[Brief recess.]

Mr. BARTON. The Subcommittee on Oversight and Investigation of the Commerce Committee will reconvene. We're going to continue our hearing on the implementation of the Balanced Budget Agreement provisions with regards to home health waste, fraud, and abuse in home health care.

Our second panel is the distinguished representative from HCFA, Ms. Linda Ruiz, who's Director of Program Integrity for the Health Care Financing Administration.

I think you know that it is the tradition to testify under oath. So you're okay with that?

Ms. RUIZ. Yes, sir.

Mr. BARTON. You also have the right to be advised by counsel. If you're going to be advised, we need to have any counselors to also be sworn in.

Ms. RUIZ. We were asked to bring our counsel and I have; Mr. Jeff Golland from the Office of General Counsel is here with me.

Mr. BARTON. Okay, would he come forward, and state for the record your name and your title.

Mr. GOLLAND. Jeffery Golland, Acting Deputy Associate General Counsel of Health Care Financing Division.

Mr. BARTON. Okay. Good.

Will each of you raise your right hand?

[Witnesses sworn.]

Be seated. Mr. Golland, you just might as well sit up here, too. It shouldn't be a problem.

Again, your written testimony is submitted for the record. We're going to recognize you for, we'll say 7 minutes, to summarize them.

TESTIMONY OF LINDA A. RUIZ, DIRECTOR OF PROGRAM INTEGRITY, HEALTH CARE FINANCING ADMINISTRATION; ACCOMPANIED BY JEFFREY GOLLAND, COUNSEL

Ms. RUIZ. Thank you.

Thank you very much for asking the Health Care Financing Administration to testify today. We appreciate this opportunity to discuss with you our initiatives to fight fraud, waste, and abuse in

home health care. As you have pointed out, we have submitted a written statement that goes over in broader detail HCFA's initiatives, and I would like to focus today on some particular items that we know are of interest to this subcommittee.

Home health care represents a way to reduce in-patient hospital costs and provides the important benefit of enabling people to stay in their homes. However, as it was very clear from the discussion surrounding the first panel, home health care has become an attractive target for unscrupulous individuals and every effort must be made to curb the threat these individuals pose to the Medicare trust fund.

This threat, as well as the growing cost of home health care, can be contained only if we are successful at preventing fraud, waste, and abuse by providers and suppliers. However, I wish to emphasize that HCFA is not seeking to curtail access for those who qualify for the benefit.

I certainly, personally, appreciate the thoughtful comments made by members of the subcommittee as I listened to the first panel. It's very clear to me that you recognize the complexities of this benefit and the complexity of the issues facing the Health Care Financing Administration in administering the benefit and in preventing fraud, waste, and abuse.

Our initiatives to combat fraud, waste, and abuse are evolving to reflect our new legislative authority and growing knowledge about the issues. Implementation of the Health Insurance Portability and Accountability Act and the Balanced Budget Act is critical to HCFA's efforts and builds upon existing program integrity processes and strategies which are really, in my view, a living document. The HIPAA and the BBA are constantly evolving to reflect new knowledge. We welcome input from your subcommittee, from the GAO, from others, and we are anxious to learn and think about new and different approaches to combating fraud, waste, and abuse.

In the broadest context, we have been pursing a strategy intended to deter fraud and abuse by focusing on four avenues: prevention, early detection, coordination, and enforcement.

The strategy for prevention, for example, focuses on paying right the first time. We do this through a number of tactics including prepayment review and automatic edits that adjust payment. HCFA's emphasis upon improving its provider enrollment procedures and requirements is certainly a preventive tactic.

Through Operation Restore Trust, we learned the importance of working closely with the States, the Department of Justice, the FBI, the Inspector General, and the private sector to share information. Coordination is a major tool in maximizing our resources to fight fraud and abuse. As a consequence, the number of law enforcement actions has significantly increased, and this has an important sentinel effect for the program.

We have, in HCFA, an enforcement responsibility as well. When we find bad apples among our many good providers, we take administrative action against them, including: suspension of payment; collection of overpayments; and when serious quality violations are identified, termination from the program. In the broadest sense of the word, we have a responsibility to prevent erroneous

payments. As Mr. Grob pointed out, the line between fraud on one end of the spectrum and an error on the other end is sometimes difficult to distinguish.

The various tactics that I have just referred to, and others, constitute HCFA's program integrity strategy, and these initiatives permit us to protect the program.

In fiscal year 1996, our Medicare contractors saved $14 for every $1 which HCFA spent by using these and other methods. About half of these savings were obtained through pre-payment claims denial or payment adjustments.

In our fiscal year 1998 budget, we are providing additional funding through the Medicare integrity program to the six regional home health intermediaries. Among other things, this will enable us to double the number of audits of home health cost reports and to increase the amount of medical review which we can perform. It will include some onsite audits by teams of both auditors and medical review personnel. We will also further our partnerships with the State survey and certification activities—agencies. Over the past years that we have been working with the States, we have been very successful, on a pilot basis, in identifying a considerable number of problems in overpayments, and we hope to continue in that effort.

Over the past years, the number of audits which we were able to conduct and the number of claims which we could review declined drastically. Even if we did not believe that there is a serious problem in this benefit, the level of review is unacceptable, and we are working to change that.

The BBA has fortified HCFA's program integrity strategy through the inclusion of a number of provisions which were discussed earlier, and we welcome those activities. We certainly agree that the implementation of the prospective payment system in a timely manner is a big challenge for HCFA, and I want to assure you that we have people working diligently on this task. I know that Nancy-Ann Min DeParle has said that she will be the first one to come back to Members of Congress and tell you if HCFA is unable to make the deadlines.

The home health agency moratorium recently announced by President Clinton is a major step in our efforts to address fraud, waste, and abuse, combined with the actions that we also announced that we are taking.

Use of the home health benefit has expanded rapidly since 1989 as a result of a variety of factors, including the Duggan v. Bowen decision, which reinterpreted the part-time or intermittent eligibility criteria in a way that vastly expanded the benefits coverage. The net result was a continuing trend of increasing home health visits per beneficiary and a large increase in the number of Medicare dependent home health agencies. These factors overburdened the existing medical review and audit resources. And, not only are you well aware of the numbers of the increases, but one of the things that we are identifying in the data is that there are vast differences from agency to agency in terms of costs and visits. And, I don't think we are, yet, able to explain why that difference exists.

Since I heard the bell, I'm going to——

Mr. BARTON. No, you waited a long time, and you can take a few more minutes.

Ms. RUIZ. Okay, thank you.

Mr. BARTON. Because we want anything you want to say, verbally, to be put in the record.

Ms. RUIZ. Well, I appreciate that. I had several meetings with your staff and I appreciate the interest and time that you are spending with us.

I do want to talk a little bit about the evolution of the moratorium, because I know that is something that you are very interested in.

In May 1997, the Department's Inspector General drafted a report on problem providers. The report included the OIG's recommendation for a moratorium until new program controls could be put in effect, although the OIG subsequently rescinded that recommendation because of discussions with HCFA. We did express reservations about a broad and unlimited moratorium, and we also expressed concern that if a home health agency is able to comply with these requirements, it should be allowed to enter the Medicare program.

I believe that you said in your introductory remarks, that HCFA is sometimes a tortoise—that is not the word you used, but that is certainly how I would interpret it—that we are conservative and sometimes slow to alter our position.

Mr. BARTON. There's nothing wrong with being conservative.

Ms. RUIZ. Well, we have always said that.

I believe that HCFA's initial reaction to the IG's recommendation is a reflection of that conservatism and that concern. And, certainly, as we came to the decision that a moratorium was something that we wanted to recommend, there was a lot of concern about the pros and cons and ramifications. I hope you will understand that there was a natural sort of reaction of: oh, no, that is something which we are unable to do. This was what was reflected in our dialog with the Inspector General.

However, I think that a lot of that dialog goes on at the staff level and once the—I sort of put it, as the—moons came together in July, and there was a lot of very public discussion about the problems in home health, I think senior officials became much more aware of the seriousness of the problem and that this was, perhaps, an unprecedented area that they needed to reconsider. And, so, what you saw, over time, over a month to 6 weeks, was a serious reevaluation of whether HCFA should continue to take a conservative position, or whether it should step outside the normal areas that it might engage in.

The importance of immediate action was very clear as we considered all the pieces of evidence put together. You pointed out just before we adjourned at the end of the last panel, that you believe that there was an error in our submission of our written testimony, and I'd certainly like to address that. I want to apologize for any miscommunication that may have occurred. We certainly have not intended to lie to the subcommittee or to misrepresent anything that did occur. I think what we intended to portray was that on behalf of the Secretary, there was a discussion with the White House. And that was done by departmental staff. The Secretary

was aware, and approved the recommendation, and we believed that the statement which we were making was made on behalf of the Secretary. So, if we misled you in some way, we certainly apologize, and I would be happy to take any other questions on that point.

[The prepared statement of Linda A. Ruiz follows:]

PREPARED STATEMENT OF LINDA A. RUIZ, DIRECTOR OF PROGRAM INTEGRITY, HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

Good morning, Mr. Chairman and Members of the Subcommittee. I appreciate this opportunity to describe the Health Care Financing Administration's initiatives to fight waste, fraud and abuse. We are proud of our success thus far, though we know that these problems will continue to challenge us.

The spiraling costs of health care have spurred the growth of the home health industry, a particular interest of this Committee, and at the same time, home health care patients have become appealing prey for unscrupulous providers and suppliers, who benefit from the isolation and vulnerability of these patients. Because health care has become an attractive target for unscrupulous individuals, both private industry and government are employing a variety of tools to combat fraud and abuse. The reforms enacted in the Balanced Budget Act (BBA) of 1997 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 provide significant new safeguards, and I would like to describe exactly how the provisions in this legislation will assist us in combating health care fraud, including that in the home health arena. Also, the Home Health Agency Moratorium recently announced by President Clinton is a major step in our efforts to address this problem. Finally, I would like to extend my thanks to you, Mr. Chairman, and the other Members of this Subcommittee, for your efforts in helping us improve Medicare and Medicaid program integrity.

LEGISLATIVE ACHIEVEMENTS

These past two years have been key legislative years, with the passage of the the Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996. The impact of these two Acts is dramatic. In particular, the changes generated by the BBA are the most significant in the history of Medicare. It is our hope that implementation of the provisions contained in this legislation will take us a step further toward eliminating fraud, waste, and abuse in Medicare and preserving the Medicare Trust Fund for future generations.

The Balanced Budget Act of 1997

The recently enacted *Balanced Budget Act of 1997* gives HCFA more authority through its anti-fraud and pro-efficiency measures. Planning for expedient and effective implementation is already underway for these anti-fraud and abuse provisions. We have set a very ambitious implementation schedule and we are committed to achieving our implementation goals. We will keep you informed of our progress and we will alert you if we encounter any significant barriers to meeting a particular deadline. The following are a number of the new provisions and our plans for implementation:

Surety Bond Requirements for DME and Other Suppliers—This provision gives HCFA the authority to require durable medical equipment (DME) suppliers, home health agencies and other types of provider facilities to post a surety bond of at least $50,000 before they are certified for both Medicare and Medicaid. We will be publishing a supplier standards regulation in the *Federal Register,* requiring a $50,000 surety bond for DME suppliers. We are contemplating a sliding scale based on the amount of Medicare billings, either a $50,000 minimum or 15 percent of the amount shown on the IRS 1099 for each supplier. We are also developing regulations to implement the surety bond requirement for home health agencies and to require a $50,000 minimum bond for comprehensive outpatient rehabilitation facilities, as required by the BBA.

Barring Felons and Improvement of the Provider Enrollment Process—The BBA provides the ability to bar convicted health care felons from ever receiving Medicare and Medicaid payments again, and to exclude the family members of sanctioned providers so that such providers can't simply transfer the business to a relative and continue operation. The Office of the Inspector General has the lead on implement-

ing this provision through regulation. Once the IG acts, HCFA will modify its provider enrollment application and contractor manual instructions to ensure that convicted health care felons no longer bill and receive payment from the Medicare program.

The authority granted by the BBA to require providers and suppliers to report their Social Security and Employer Identification Numbers is a significant tool in identifying fraudulent providers. This provision allows us to track providers and gives the Secretary authority to deny Medicare entry for provider applicants who have been convicted of a felony. If an application is denied, a 6-month waiting period must be completed before the provider may reapply. However, the Secretary must first report to the Congress on the privacy and protection of Social Security numbers. HCFA will be working closely with the Social Security Administration (SSA) and the Internal Revenue Service (IRS) to define the privacy and protection guidelines and successfully implement the regulation.

Home Health Prospective Payment System—This provision allows HCFA to establish a prospective payment system (PPS) that will pay providers a unit of payment for an episode of care. PPS will provide incentives to home health agencies to make the most appropriate use of resources and, over the long-term, will help control overall expenditures. It also will end "periodic interim payments" that are made in advance and not reconciled until the end of each year. The law provides the authority to establish a prospective payment system by October 1, 1999, and we are working hard to meet that date with the necessary research and infrastructure development. Meanwhile, an interim payment system was established in the BBA.

Clarification of Intermittent Skilled Nursing Care—Once beneficiaries meet all of the eligibility criteria to qualify for the home health benefit (need of intermittent skilled nursing care or physical therapy or speech-language pathology; homebound; and under the care of a physician), the benefit covers part-time or intermittent skilled nursing care and home health aide services. This provision defines "intermittent" for purposes of eligibility and "part-time or intermittent" for purposes of coverage under the law. We have issued instructions for the 10/1/97 effective date.

No Home Health Benefits Based Solely on Venipuncture—Previously, venipuncture (surgical puncture of a vein) qualified as skilled nursing care and enabled a beneficiary to meet the eligibility criterion for intermittent skilled nursing services under the home health benefit. Thus, if the other criteria were met (homebound, etc.), then a beneficiary who only required venipuncture would have been entitled to all of the other covered home health services including home health aide services. Effective 2/5/98, if venipuncture for the purpose of obtaining a blood sample is the *only* skilled service that is needed by the beneficiary, that individual will not qualify for *all* the benefits under home health.

Home Health Agency/Hospice Billing Based on Location of Services—This provision will require billing to be based on the location of service delivered rather than the location of the agency, so the Medicare payment will no longer be based on the higher wage rates for urban areas for care delivered in low-cost areas. There will be no interruption in payments since fiscal intermediaries can invoke emergency procedures to make "accelerated" payments if there is a delay in submitting or processing claims. Under these procedures, historical claims experience can be used to make estimated payments.

Development of Normative Utilization Standards—This provision gives HCFA the authority to develop normative utilization standards and deny payment to agencies that bill for services in excess of these standards. We are currently considering how most effectively to implement this critical provision.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The BBA's provisions will significantly enhance our ability to prevent fraud and abuse, but it is important to acknowledge the fundamental role that HIPAA provisions have played as the foundation for the BBA provisions. HIPAA also included a number of key anti-fraud provisions, of which I would like to mention just a few:

Fraud and Abuse Control Program—The program integrity activities of the Medicare contractors initiate many of the cases subsequently developed by the Office of Inspector General and Federal Bureau of Investigation, and support their prosecution by the Department of Justice. Using monies made available through the Fraud and Abuse Control Fund, we expanded our successful two-year Operation Restore Trust (ORT) demonstration from the 5 original ORT States (California, Florida, Illinois, New York, Texas) to 15 additional States (Arkansas, Connecticut, Indiana, Louisiana, Massachusetts, Minnesota, Missouri, New Jersey, Ohio, Oklahoma, South Dakota, Tennessee, Utah, Virginia, Wyoming). This was made possible by a $1.8 million allocation to HCFA for "Project ORT" in 1997, through HIPAA's Fraud and Abuse Control Program. Nineteen States are now participating in a total of 27

HIPAA-funded projects, allowing us to survey approximately 300 providers for both certification and payment issues. These surveys will be made of providers of home health services, skilled nursing services, outpatient physical therapy services, and laboratory services, as well as psychiatric services in both hospitals and community mental health centers.

Medicare Integrity Program (MIP)—The MIP authorized the Secretary to promote the integrity of the Medicare program by entering into contracts with eligible entities to carry out activities such as audits of cost reports, medical and utilization review, and payment determinations. The MIP provided a stable source of funding for HCFA's program integrity activities, and gave us authority to contract for these activities with *any* qualified entity, *not* just those insurance companies who are currently our fiscal intermediaries or carriers. Using competitive procedures as established in the *Federal Acquisition Regulations* system, we are now able to attract a variety of offerors who will propose innovative approaches to implement the MIP. The MIP also permitted HCFA to require our contractors to report situations which may constitute conflicts of interest, thus minimizing the number of instances where there is either an actual, or an apparent, conflict of interest. This is a concern particularly when intermediaries and carriers are also private health insurance companies who purchase health care entities.

Beneficiary Notification—An equally important program integrity priority for HCFA is beneficiary information. HIPAA required that HCFA send each beneficiary an Explanation of Medicare Benefits (EOMB) statement, which itemizes actions that Medicare has taken on claims filed. We have learned that better-informed customers can actually help fight fraud and abuse, and we currently receive and investigate an overwhelming number of inquiries from beneficiaries alerting us to questionable services on their statements. All of our carriers have 1-800 numbers which appear at the bottom of the EOMB, encouraging beneficiaries to call with questions about their claims. By expanding our consumer information programs, we are ensuring that Medicare beneficiaries receive current, easy-to-understand, and unambiguous information in a timely manner, so that they may assist us in identifying improper claims and erroneous bills.

National Provider Identifier (NPI), an industry-wide unique identifier for providers and suppliers, will be used to create databases of all providers and suppliers who bill Medicare. This database will be available to the Medicare contractors processing claims so they can automatically deny or give greater scrutiny to claims associated with abusive billers. We plan to publish a proposed regulation defining the NPI as the national standard later this fall. We will then begin issuing NPIs to providers in late 1998 or early 1999 and phase in national implementation over the next few years.

Sanction of Providers for Fraud and Abuse—HIPAA required the Secretary to exclude from Medicare and Medicaid providers with felony convictions related to health care fraud or controlled substances, and gave the Secretary greater flexibility to exclude providers convicted of misdemeanors or who violate Medicare quality rules. The DHHS Inspector General will implement this provision.

Adverse Action Data Base—To ensure that our computer capabilities are commensurate with our program integrity goals, HIPAA established a database, the Adverse Action Data Base, which coordinates with, but does not duplicate, the National Practitioner Data Bank. The database will include providers, suppliers and practitioners against which final adverse actions have been taken. The Health Resources and Services Administration (HRSA) is coordinating this database.

Transfer of Assets to Obtain Medicaid Eligibility—HIPAA makes knowing and willful transfer of assets to gain eligibility for Medicaid subject to criminal penalties—including civil monetary penalties or prison—if the transfer resulted in a period of ineligibility. This was amended by BBA to clarify that the penalties apply to the advisor, not the beneficiary. Implementation of this initiative rests with the Department of Justice.

HOME HEALTH ISSUES

Background

The recent national attention to fraud and abuse in the home health industry has caused Congress, consumer groups, and government agencies to sharpen their focus on problems specific to home health care. However, this is not a new concern, nor one which we have only recently addressed. Use of the home health benefit has expanded rapidly since 1989 as a result of a variety of factors for which the court case *Duggan v. Bowen* was a catalyst. The net result of these factors was a continuing trend of increased home health visits per beneficiary that overburdened the existing medical review resources. Home health statistics give a general idea of the indus-

try's growth: in 1990, there were 5,656 HHAs, with the typical patient receiving an average of 33 visits. By 1996, the number of HHAs had nearly doubled at 9,800, with an average of 76 visits per patient.

In 1993 an intra-HCFA group, called the Home Health Initiative workgroup, was charged with conducting a thorough analysis of the Medicare home health benefit. The Home Health Initiative workgroup was tasked with what was, in effect, a zero-based review of Medicare's home health benefit for purposes of identifying potential changes in three areas: (1) program areas where improvements could be made within the constraints of current law, (2) areas of program abuse or waste which could be dealt with under current authorities, and (3) statutory changes that could be recommended as a means either of improving the overall character of the benefit or of strengthening HCFA's efforts to administer it effectively. The Home Health Initiative was the beginning of what has become a continuous effort by HCFA, both alone and in partnership with the OIG, to deal with problems in Medicare's home health benefit. Operation Restore Trust (ORT), for example, has a major focus on home health and encompasses a wide range of projects aimed at eliminating fraud schemes and areas of vulnerability.

The Home Health Moratorium

The Department's Office of Inspector General (OIG) initially proposed a moratorium on certifying new home health agencies (HHAs) until new program controls could be put into effect. In May 1997 the OIG released a draft report entitled, "Home Health: Problem Providers and Their Impact on Medicare," which included the OIG's recommendation for a moratorium.

Prior to the report's release in July 1997, the OIG withdrew its recommendation for a moratorium, noting that the outcome of numerous legislative proposals addressing home health fraud were pending before the Congress in its deliberations over the budget. The OIG's report indicated its view that if enacted, these proposals would strengthen HCFA's ability to curb abuses, but went on to say that if inappropriate payments continues, the moratorium should be considered as an appropriate action while HCFA builds control mechanisms.

When the Balanced Budget Act (BBA) was enacted in August 1997, it included many, but not all, of the OIG's proposals. The Administration was pleased with the number of tools the BBA provided to combat waste, fraud and abuse in the home health industry. But the release of the OIG's report in July 1997, stating that approximately 40 percent of Medicare home health payments in four of the five Operation Restore Trust states were inappropriate, highlighted the importance of more immediate action. The HCFA Administrator and the Deputy Administrator requested that HCFA staff develop options for an aggressive response to this situation. HCFA developed a number of options. Secretary Shalala recommended to the President that a temporary moratorium on new home health agencies entering the Medicare program was necessary to give the Department time to focus on measures to strengthen home health requirements and to implement the some of the program safeguards included in the BBA.

As a result, on September 15, 1997, President Clinton announced a temporary moratorium on the entry of new HHAs into the Medicare program while HCFA writes regulations and develops new procedures to strengthen the requirements for HHAs providing services to Medicare beneficiaries. The moratorium began on September 15, is expected to last until an interim final regulation is published (approximately 6 months), and applies to any home health agency that had not successfully completed a survey or submitted appropriate paperwork with an effective date of September 15.

Although HCFA staff had previously expressed reservations about a moratorium in the context of the earlier recommendations of the Inspector General, the issue was reexamined carefully at the request of HCFA's new Deputy Administrator, who expressed concern that current home health program requirements and safeguards were not sufficient to protect the integrity of the Medicare program. Accordingly, HCFA asked the Office of the General Counsel for an opinion as to the Secretary's authority to impose a temporary moratorium. Counsel's opinion was that the provision set forth in section 1891(b) of the Social Security Act established a strong duty and responsibility for the Secretary to assure the quality and fiscal integrity of the home health benefit, and thus supported a moratorium. The moratorium is a valuable addition to the Administration's long-range strategies, and is designed to reduce the likelihood of "fly-by-night" providers entering the program, while HCFA strengthens its requirements to fight waste and abuse. HCFA has directed additional resources of the Medicare Integrity Program to double the number of home health cost report audits, and increase the number of claims reviewed for medical

necessity by 25 percent. We believe the steps we are taking will enhance quality of care in HHAs as well.

We expect the moratorium to last six months, during which time the Department will implement provisions included in the BBA and also develop more stringent business standards for home health agencies. First, there is the DHHS-implemented statutory requirement that HHAs post at least a $50,000 surety bond before they are certified. Additionally, a related rule will require new agencies to have enough funds on hand to operate for the first three to six months. These requirements will help establish the financial stability of home health providers. Other regulations will include requirements for information from HHA owners about related businesses they may own; reenrollment of HHAs every three years with independent audits each time; and Medicare certification based on experience serving a minimum number of patients. Finally, we are in the process of completing a final regulation to require HHAs to conduct criminal background checks of the aides they hire and to be more accountable for the care they provide. In conjunction with this regulation, new videos and brochures will be designed to teach beneficiaries how to detect and report fraud and abuse.

The Department's initiatives to combat waste, fraud and abuse are constantly evolving to reflect new legislative authority and knowledge about the issues. The HIPAA and BBA legislation has been critical to our efforts but is effective primarily because our internal program integrity processes and strategies are complementary to the legislation. Essentially, successful implementation of these legislative acts requires a strong internal organization—and a strong program integrity strategy.

HCFA'S PROGRAM INTEGRITY STRATEGY

Many of the preceding provisions specifically targeted home health fraud and abuse. In a broader sense, the Administration is pursuing a strategy intended to deter fraud and abuse on every front—our strategy focuses on *prevention, early detection, coordination, and enforcement.* Prevention is the best means we have to guarantee the initial accuracy of both claims and payments, and to avoid having to "pay and chase", a lengthy, uncertain and expensive process. Early detection is a second key ingredient of our approach. We can identify patterns of fraudulent activity early by using data to monitor unusual billing patterns and other indicators of the integrity and financial status of providers, promptly identifying and collecting overpayments, and making appropriate referrals to law enforcement.

Cooperation with our partners in the law enforcement arena is one way we can maximize our success. Through Operation Restore Trust, we learned the importance of working closely with the States, the Department of Justice, including the FBI, the Inspector General and the private sector to share information and tactics for fighting fraud and abuse.

Finally, when we find "bad apples" among our many good providers, we must take enforcement action against them, including suspension of payment, referral to the OIG for potential exclusion from the program, disenrollment, collection of overpayments, and imposition of civil money penalties. Investing in prevention, early detection and enforcement has a proven record of returns to the Medicare Trust Fund. In FY 1996, every dollar spent by our Medicare contractors using these methods yielded $14 in return.

Prevention, detection, coordination, and enforcement—these terms are more than just buzzwords or campaign phrases. They are the actual cornerstones for HCFA's anti-fraud strategy, which we plan to apply aggressively toward the fight against fraud, waste, and abuse in the home health industry.

REMAINING TASKS AND FUTURE CHALLENGES

Some of the anti-fraud proposals in the President's Bill were not included in the Balanced Budget Act of 1997, and we believe it is important to identify them and explain why they are critical to the overall success of our program integrity efforts.

Bankruptcy Provisions—These proposals would protect Medicare and Medicaid interests in bankruptcy cases. A provider would still be liable to refund overpayments and pay penalties and fines, even if that individual filed for bankruptcy. Quality of care penalties could be imposed and collected even if a provider was in bankruptcy. Medicare suspensions and exclusions (including for scholarship loan defaults) would still be in force even if a provider files for bankruptcy. If Medicare law and bankruptcy law conflict, Medicare law would prevail. Bankruptcy courts would not be able to re-adjudicate our coverage and/or payment decisions.

Kickback Penalties—Subsequent to the 1995 Hanlester Network v. Shalala decision, a very high burden of proof was put on the government in proving the existence of kickbacks. To ensure that our fraud detection efforts are not in vain, legisla-

tion is needed to establish the same burden of proof under the anti-kickback laws as with other criminal statutes. Although there is a general kickback statute covering health plans subject to ERISA, there is also a need to expand the criminal penalties by extending Federal anti-kickback criminal sanctions to all other public and private health care programs and plans.

Medicare Provider and Supplier Agreement Fee—This proposal would authorize the Secretary to collect a fee for enrollment or re-enrollment of Medicare providers or suppliers. The fee would cover administrative costs and generate considerable savings for the Medicare and Medicaid programs.

Extension of Subpoena and Injunction Authority—This proposal would extend the testimonial subpoena power and injunctive authority that the Secretary has for civil money penalties to other administrative sanctions such as exclusions against Federal health care program providers. These investigative tools are needed in the complex investigations of fraud, kickbacks and other prohibited activities.

Liability of Physicians in Speciality Hospitals—Under the anti-dumping statute, this proposal would clarify that physicians who are "on call" to a specialty unit of a hospital (e.g. a burn center) must respond to a call from the hospital to come in, to examine and stabilize the emergency medical condition of an individual who is proposed to be transferred to that unit from another hospital. This proposal would close a loophole which has prevented the Inspector General from imposing civil monetary penalties against physicians who are on-call for specialized services.

Prospective Payment System for Rural Health Clinic Services (RHCs)—The Secretary would develop a prospective payment system for RHCs no later than December 31, 2000. A prospective payment system would remove the incentives for providers to inflate their charges and would work to ensure that Medicare was only paying appropriate costs.

Decreased Beneficiary Cost Sharing for Rural Health Clinic Services—Under a prospective payment system, beneficiary cost sharing would be based on 20 percent of the PPS amount. Beneficiary cost sharing (prior to the development of a PPS system) could not exceed 20 percent Medicare's payment limit. A 20 percent cost-sharing limit would be consistent with current Administration policy to ensure that beneficiaries do not pay more than 20 percent of the amount that the provider receives from Medicare.

Partial Hospitalization Services Not to be Furnished in Residential Settings—This proposal would preclude providers from furnishing partial hospitalization services in a patient's home or in an inpatient or other residential setting. This proposal would discourage development of partial hospitalization programs targeted to patients in their homes or in settings where there is a residential population, such as nursing facilities and assisted living facilities.

Community Mental Health Center (CMHC) Prospective Payment System—This proposal would provide the Secretary broad authority to establish through regulation a prospective payment system that reflects appropriate payment levels for efficient providers of partial hospitalization services and payment levels for similar services in other delivery systems. The current cost reimbursement system would stay in place until the Secretary exercises this payment authority. The partial hospitalization benefit was intended to be a less-costly alternative to inpatient psychiatric care. The current reasonable cost reimbursement methodology has resulted in excessive payment and inappropriate payment for items and services that are excluded from the definition of partial hospitalization services.

Insurer Information Reporting—This proposal would build on HCFA's prospective data sharing initiative to clarify that Medicare can require information from all group health plans in order to ensure that Medicare is paying the appropriate amount for beneficiaries who may be covered by private insurance. The problem of Medicare's initially paying and then attempting to recover payment (or not having enough time to recover payment) from a group health plan could largely be eliminated if all group health plans were required to report to us information about the insurance coverage of Medicare beneficiaries. We would then know from the start what our payment obligations are (i.e., if Medicare is responsible for paying most of a claim or whether Medicare is responsible only for the co-payment and deductible). The appropriate payments could be made in a timely fashion and resources would not need to be spent to recoup mistaken payments.

Conditions for Double Damages—This proposal would provide that when a third party payer is required to reimburse Medicare, double damages are payable unless the third party payer can demonstrate that it did not know, and could not have known, of its responsibility to pay first. This would reduce "gaming" of the system by third party payers.

Clarification of Time and Filing Limitations—This proposal would clarify that Medicare can recover mistaken payments from all entities that make insurance pay-

ments, without a time limit upon when Medicare can file a claim. Unfortunately, because we must utilize information from tax returns, which is then matched against information from the SSA, by the time we receive data it is already one and a half, and sometimes two, years old. We must then match this information against Medicare files before a questionnaire can be sent to identified employers to determine if a Medicare beneficiary (or their spouse) had coverage through the group health plan of an employer. Thus, the current three-year limit for recovery of erroneous Medicare payments effectively means that *no* erroneous primary payments are collected. Consequently, private insurance companies (whose obligation it is to pay *before* Medicare when the beneficiary has a primary policy) receive substantial windfalls at the expense of the Medicare Trust Fund.

Technical Changes Concerning Minimum Sizes of Group Health Plans—This proposal would make technical changes concerning the minimum sizes of group health plans so that the Social Security Act and the IRS Code would not be contradictory.

Eliminate Exception to Anti-kickback Statute for Certain Managed Care Plans—The term "substantial financial risk" is undefined and somewhat broad. This proposal would eliminate the broad new exception (created in HIPAA) to the anti-kickback statute when providers are at "substantial financial risk." The Congressional Budget Office assigned a considerable cost to this provision precisely because it could be easily abused by those wishing to profit from referrals.

Repeal of Clarification Concerning Levels of Knowledge Required for Imposition of CMPs—This proposal would reinstate the reasonable diligence standard that the OIG used to levy civil money penalties on Federal health care program providers who violated the law. HIPAA eliminated the standard for use of reasonable diligence and made providers subject to civil money penalties only if they acted with deliberate ignorance or reckless disregard.

Civil Monetary Penalties—We think it is of the utmost importance to have the appropriate penalties for providers found guilty of defrauding Medicare. Without appropriate sanctions, anti-fraud laws will have little effect. There a several proposals that would create new civil monetary penalties for: false certification of Medicare eligibility, prior knowledge of claims submitted by excluded providers; and acceptance of requests from excluded providers (i.e. pharmacy services). In addition, specific dollar amounts would be specified for cases of repetitive overbilling and unallowed charges.

We believe that these provisions are needed to address areas of vulnerability that are not covered by existing legislation, and that they will provide us with additional valuable weapons in the war against fraud and abuse. We need Congressional support to add these important tools to our current efforts.

CONCLUSION

As the nation's largest purchaser of health care services and as the health care insurer for one in four Americans, we know that it is the most vulnerable—the oldest, the frailest, the least able—who are the first to be victimized. It is no coincidence that these individuals are often also recipients of home health care, and we need to ensure that their Medicare dollars and those of all Medicare beneficiaries are protected from potential scam artists.

Health care is the fastest growing sector of the economy and therefore an area most likely to be targeted by fraudulent providers and suppliers. The answer to this problem lies in a combination of legislative and administrative solutions: through implementation of HIPAA and the BBA and increased program integrity efforts, we will safeguard Medicare for future generations. These solutions will not only strengthen the payment safeguards we already have in place, but will expand and enhance them. There will always be unscrupulous providers and questionable billing practices—but with the tools provided to us in the BBA and our new, stricter standards, we will have the ability to be one step ahead of them.

Mr. BARTON. Let me comment on that.

Ms. RUIZ. Okay.

Mr. BARTON. I said at the last hearing, the subcommittee is going to try a new model in that we're not going to try to be confrontational with the administration because this is too big a problem. And, it's bipartisan—There's nobody that's for fraud, waste, and abuse in Medicare. So, this is one of those rare things where we ought to be able to work together whether we are conservative, liberal; Republican, Democrat; legislative branch, execu-

tive branch. But, having said that, there has to be honesty in communication.

Ms. RUIZ. We agree.

Mr. BARTON. Now, you can go either way on whether there should be a moratorium. There are good policy reasons to say we ought to call a halt and not let any more home health care agencies be certified. You can also say: well, if there are good providers out there that have met the criteria, we should let them. What you can't do is take a position where you mislead the subcommittee, and the full committee, and the chairman of the full committee, and the subcommittee chairman of this committee, on what you're position is.

Ms. RUIZ. Yes, sir. We intend——

Mr. BARTON. We have, in writing, several times, that Secretary Shalala recommended to the President that this moratorium be implemented. That is an incorrect statement.

Ms. RUIZ. If you interpret it as meaning personally spoke to him, I believe you are right, sir.

Mr. BARTON. Well, I don't know how else you can interpret it.

Also—we see no documentation—we have a lot of documentation with the Inspector General at HHS that is recommending back in May that this moratorium be imposed. And, we have documentation where HCFA, for probably valid reasons, has got some concerns about that. We have no documentation where anything went forward from HHS to the White House saying the moratorium should be imposed.

It appears, to the committee staff, that—and I'm giving an opinion here, not necessarily a fact—that the White House decided for political reasons to impose this moratorium, and basically did it, and then told everybody else to get with the program.

Now, for an issue that's as important as this, it should go the other way. There should be a rational policy debate. There should be back and forth. There should be a cabinet agency task force put together in which a recommendation is made to the President with various options and the President chooses.

Again, I'm not taking a position on the policy, but I'm definitely taking a position that if we're going to work together to try to really do what's best for the American people, that HCFA has got to shoot straight with the subcommittee, period.

Ms. RUIZ. And we are trying to. We really are. There was no intent to mislead. And, I want to assure you about that. I also want to assure you, since I was very much involved in all the staff discussions—I was never involved in the discussions with the White House about the recommendation, and therefore, I cannot personally speak to those things—but I know that I never heard nor was told that the White House told us what to do. In fact, I was under the distinct impression that we were going to make recommendations to the White House. We spent a great deal of time going over a lot of different options. We did make these recommendations, first to the Deputy Secretary, and then through departmental staff, to the White House. Therefore, I do not personally believe, nor do I have any evidence to suggest, that the White House instructed HCFA to do this.

At the same time that there is no evidence that we recommended this on paper, I agree with you. There is no such piece of paper. There is also no evidence to suggest that the White House told us what to do either. So, the best I can ask you to do is to believe a career civil servant who is telling you, to the best of her knowledge, and with honesty, what occurred within her sphere of knowledge.

Mr. BARTON. Well, a major policy decision doesn't just kind of morph out of thin air. I mean, at least it shouldn't.

Ms. RUIZ. No.

Mr. BARTON. Even in this administration.

Ms. RUIZ. Right.

Mr. BARTON. It shouldn't. I mean, there should be some documentation. I think the committee has made its point. We expect honesty if we're going to cooperate. We expect cooperation to be reciprocal. And, in my meeting with the designee, the head of HCFA, she certainly convinced me that she wants to cooperate.

Ms. RUIZ. Right.

Mr. BARTON. And, I'm going to operate in a good faith fashion on that.

I do want to ask some questions.

Ms. RUIZ. Okay.

Mr. BARTON. So the Chair is going to recognize itself for the first 10 minutes of questions.

Ms. RUIZ. All right.

Mr. BARTON. And, my first question is: you're here because the designee has not been confirmed by the Senate. We understand that. So, we appreciate your attendance.

Ms. RUIZ. Sure.

Mr. BARTON. But, you are a career civil servant; you're not a political appointee? Is that correct?

Ms. RUIZ. Yes, sir; that is correct.

Mr. BARTON. Okay. Could you explain to the subcommittee what the Office of Program Integrity actually is responsible for within HCFA?

Ms. RUIZ. Okay.

My office is responsible for the oversight and direction of all program integrity activities for the Health Care Financing Administration.

Mr. BARTON. What does that mean? What does "program integrity" mean?

Ms. RUIZ. Okay.

To me, program integrity means—I do not know that there is a formal definition, but to me, it means—ensuring that HCFA is paying correctly. And so, at a minimum, its fraud, waste, and abuse. And you might say that waste is defined as errors so that that covers everything. I think people could argue about that, but, my office, personally, has direct oversight for the Medicare contractors on medical review and fraud and abuse.

Another group that we work closely with, includes audits and Medicare secondary payer. However, I also have oversight and coordination responsibilities for managed care and Medicaid. The Medicare integrity program's budget is paying for, and overseeing, activities like the Correct Coding Initiative, which one could argue, is not designed to identify fraud, but just simply to make sure that

we pay correctly. This is part of program integrity—it is the fiscal integrity of the program.

Mr. BARTON. Now, how long has your office been in existence within HCFA.

Ms. RUIZ. Since the reorganization in July.

Mr. BARTON. So, this is a brand-new office.

Ms. RUIZ. That is correct. Now, we had these functions; which I previously performed in another capacity.

Mr. BARTON. You did?

Ms. RUIZ. Yes, I did. I was responsible, simply, for oversight of the Medicare contractors for medical review, audit, fraud and abuse, and Medicare secondary payer. In the reorganization, we shuffled things just a little bit, and the previous duties of the former Senior Advisor to the Administrator, Judy Berek, before the reorganization, have been assigned to me. I have a dotted line directly to the Administrator for purposes of dealing with program integrity issues. HCFA's Administrator has just formed a fraud and abuse steering committee which she will personally chair and I will support her in my new capacity. This involves cross-cutting across the agency to consider problems with fraud, waste, and abuse and determining how the agency should address these problems.

Mr. BARTON. Now, do you agree or disagree, that in the past HCFA has been more concerned about being an efficient processor as opposed to trying to look at some of the policy implications and at least take—a position on policy changes?

Ms. RUIZ. I would say, up until about 1993 or 1994, that was certainly correct. We were very concerned about building access to the program, ensuring that claims were timely processed, and increasing our electronic submission of claims—all the things that go to timely processing of claims. However, I first became associated with HCFA's fraud and abuse activities in 1993. The first thing that happened was that I was stunned to find out that my job was now going to have a major focus on these activities, since it was becoming a very important focus of HCFA's program. Ever since that time, I believe that we have been working to build a strategy to increase our resources. The Medicare integrity program was something that HCFA requested. HCFA is trying to administer this program in an appropriate way. Therefore, I believe that we have witnessed an increasing level of responsibility and accountability in terms of fraud and abuse.

Mr. BARTON. Now, is it safe to assume that the position that you hold in HCFA on a day-to-day basis is the No. 1 position in terms of focusing on fraud, waste, and abuse?

Ms. RUIZ. Yes, sir.

Mr. BARTON. Okay.

Ms. RUIZ. Other than the Administrator.

Mr. BARTON. I understand that.

Ms. RUIZ. Whose taking a very personal interest in that.

Mr. BARTON. Since you're the No. 1 watchdog, what do you consider to be the goal for the next fiscal year—in terms of beginning to see the trend line go down on percentages? Now, the previous panel indicated 40 percent plus or minus 2 percent in the four States that were reviewed. Do you want to set a goal to see that drop to 30 percent? 35 percent? 25 percent? 20 percent? What

would you consider to be success if we conducted an audit a year from now in terms of percentage of waste, fraud, and abuse in the home health care program?

Ms. RUIZ. That is a very good question, Mr. Barton. Actually, we set our goals a little more broadly for this year, and some of them have to do with the results of the Chief Financial Officer audit of which home health is a part. And our goal is to reduce the error rate over a 5-year period going down about 4 percent over that 5-year period. A little at a time.

Mr. BARTON. Four percent each year?

Ms. RUIZ. No. A total of 4 percent. I think——

Mr. BARTON. You're telling me that your goal, 5 years from now, is 35 percent?

Ms. RUIZ. Well, I am talking about all different kinds of services. The error rate for all services is 14 percent. And, that is a lot of dollars; that is $23 billion. Therefore, our goal over 5 years is to reduce the overall error rate to 10 percent. I know that the——

Mr. BARTON. Now, I don't want to get confused in terminology, here.

Ms. RUIZ. Right.

Mr. BARTON. We're talking about a 40 percent waste, fraud, and abuse number, which means that 40 percent of the payments in home health care should not have been paid. You're using the term "error rate?"

Ms. RUIZ. Yes, sir.

Mr. BARTON. Is "error rate" HCFA terminology for waste, fraud, and abuse? Or, is that something different?

Ms. RUIZ. Error rate is actually the Office of Inspector General's terminology for the Chief Financial Officer's audit that the OIG conducted for the first time in fiscal year 1996. That was a broader look that encompasses not only fraud, waste, and abuse, but all errors made in terms of payment for all types of services they looked at, which was everything except durable medical equipment.

I do not know that there is any way to specifically correlate the overall error rate with the finding that the OIG made for the four States of Operation Restore process.

Mr. BARTON. Let me interrupt you. I've been subcommittee chairman of this subcommittee for 3 years. We've done investigations on EPA, Department of Energy, Food and Drug Administration, on, and on, and on. Especially with the Department of Energy, we have found, repeatedly, that they simply don't have the ability to determine a goal and then to develop a plan of action to implement and achieve the goal.

Now, you said under oath, that you're the No. 1 person within HCFA, other than the Administrator, to combat, or monitor on a day-to-day basis, waste, fraud, and abuse. We're not going to get anywhere if you in your own mind don't come up with a goal of how you want to see this waste, fraud, and abuse number begin to go down.

And, it is not acceptable, at least to the chairman of the subcommittee, to have a goal of 5 years from now as seeing that error rate go down 4 percent. I mean, 40 percent of $16 billion is $6.5 billion. I don't think anybody whose elected to Congress can go out

to the public and say, "We're going to let $6.5 billion be wasted every year for the next 5 years."

Because the program is growing so rapidly that if you save 1 percent a year, you're still going to end up having more waste, fraud, and abuse.

You see what I'm saying?

Ms. RUIZ. Yes, sir; I do. I believe that it is a big dilemma for HCFA, frankly. We had a lot of debate about what that goal should be. The first thing which I would like to say is: that it is not a direct correlation. We are not able to directly correlate the 14 percent error rate with the 40 percent error rate in home health. I do not know how to correlate these rates because home health is connected with everything that we are paying. If what you are saying is that I should separately develop a goal for home health, that is a very good point, and I will certainly——

Mr. BARTON. Well, don't you think you should?

Ms. RUIZ. Well, yes, sir. The problem is that I should have a separate goal for every service. And, so——

Mr. BARTON. Well?

Ms. RUIZ. The dilemma for HCFA is: how many things can we possibly address at any one time? We do have a corrective action plan for the Chief Financial Officer's audit, which includes a portion for home health. We are currently in the process of developing a tactical plan for all of HCFA's services. In fact, this is part of what this fraud and abuse steering committee is going to be working on.

We recognize the need for establishing goals and for planning. I am unable to say to you today that, "I have a specific numerical goal on how much I can reduce home health this year."

Mr. BARTON. Do you think you should, though?

Ms. RUIZ. I think it's——

Mr. BARTON. I mean one of the rules, if you don't have a target, you're unlikely to hit anything.

Ms. RUIZ. Yes. Well, you are absolutely right. I believe that we promised to double the number of audits and medical reviews. In fact, our regional home health intermediaries are in this week, and we have been meeting with them. We determined a plan yesterday on how to best accomplish this goal. It is difficult for me to predict exactly what this will achieve in terms of a reduction. I could speculate and predict a specific goal. Will I actually get there? I am not sure, but, certainly you make a good point.

Mr. BARTON. Well, my time's expired, and we've got three other members here.

But, I just want you to know, it is not going to be acceptable, as long as I'm subcommittee chairman, to have you or anybody else from HCFA come up here once a year and talk in general terms about some grand scheme that's going to happen 5 years from now.

Ms. RUIZ. I understand.

Mr. BARTON. I am going to work with the designee of the President, as soon as she is confirmed, and we're going to, on a joint basis, develop some goals. If we have to put it in legislative law, you know, I'll try to get bipartisan support to that. But in my mind, I think you ought to set a goal of a 10 percent reduction in waste, fraud, and abuse this year. Let's move that from 40 percent

to 30 percent. And then from 30 percent to 20 percent. And let's go on down. Now, you will never get to zero, but you cannot be successful, by saying, 5 years from now we're going to reduce it 4 percent. That is a recipe for disaster. It simply is.

Ms. RUIZ. I think I have to say, that Mrs. DeParle would agree with you, and she would want to work very closely with the subcommittee and other Members of Congress to set goals. We would be happy to work with you regarding this matter.

Mr. BARTON. Now, I've got a whole series of questions about copayments and the prospective payment system and how you're going to implement that, and if we have time we'll come back and I'll ask some of those. If not, we'll submit those for the record.

I'm going to recognize Dr. Ganske, because he was here before I came back. We'll let Dr. Ganske ask his questions and then we'll go to Mr. Klink.

Mr. GANSKE. Well, thank you, Mr. Chairman.

You know, numerous reports of the GAO and others have seen continued problems in the home health benefit springing from the failure to properly define the term "homebound." One fraud investigator was quoted earlier this year as saying, "There are lots of walking wounded out there playing golf." So what I would like to know is: what steps are HCFA taking to develop and enforce a definition of homebound that will ensure that home health benefits are being provided only to those who truly should qualify?

Ms. RUIZ. You are probably aware, Dr. Ganske, that in the President's submission for legislation in 1997, we submitted a proposed definition of homebound which was not enacted into law. Instead, what we received was a requirement to perform a study which is due next October, I believe. We are in the process of putting together the time line and the plan for that study. You were not here for the first panel—but I listened with great interest to the ideas and the concerns expressed by members of the subcommittee. We would be happy to have input from all of you about what that definition should be and how we should perform the study. We believe that it is important to have a definition. That is why we submitted a proposal last year.

Mr. GANSKE. Okay. We'll I may be going over some questions that have been asked before, but, tell me—you know, we're looking at a prospective payment system.

Ms. RUIZ. Yes.

Mr. GANSKE. I'm just curious, what is the time line for having that done?

Ms. RUIZ. Prospective payment, you know, there is a legislative time line that I believe is October 1999. That is a very aggressive time line. We are just now completing phases of a demonstration project that started a couple of years ago. It is a 3-year demonstration project designed to collect the data that would go into designing the prospective payment system. I have had several discussions with individuals in the agency who are responsible for implementing this piece, and they are working very diligently to try to meet that time line.

We recognize that there are a number of issues surrounding the implications of a prospective payment system, such as what the data should be. We recognize the importance of a good case mix ad-

juster. We are trying to make sure that the demonstration gives us that data. I am not certain that I can say today whether that would be the case. We are currently evaluating the results. I believe that we are committed to trying to meet the deadline, but we are also committed to letting you know if we are unable to comply. I think the last thing we want to do is to implement a system that is poorly thought through or is based on unreliable data.

Mr. GANSKE. Well, are you going to have information in say, 6 months, that will help us know whether you're going to be able to keep that October 1999 date?

Ms. RUIZ. I would say, yes. I think we believe that by April 1998, that we will have a good sense of where we are going and whether we have everything we need. We would be happy to keep you informed on an interim basis.

Mr. GANSKE. Okay. Well, many people: Members of Congress—House and Senate—the GAO, the IG, have called for a small co-payment on home health care services, to include some type of beneficiary responsibility in this area. I mean, we have co-payments for physician services, we have deductibles for hospitalization. I suspect that this will be an issue that will be discussed in the Medicare Commission as one of the options for ensuring longer-term solvency. Just give me your feelings on that. I mean, if for instance, you had provisions in there to take into account those at the lower-end of an income scale where it would be most difficult; and if you had some type of provision that for the first 50, 100 visits there would be no co-payment, but was one for the longer-range multiple service home health care patients; what would be wrong with a $1 or a $5 co-payment for at least those that you could identify as having some resources? At one point in time the administration had talked about, favorably, of means testing for senior citizens—wealthy senior citizens.

Ms. RUIZ. This is, I believe, a controversial subject, and one could argue both sides of this issue. I, first of all, believe that I would point out that I agree with Mr. Scanlon who said earlier in the first panel that one of the issues associated with co-payments is the fact that probably 85 percent of Medicare beneficiaries have some kind of supplemental insurance, and another 5 to 10 percent have Medicaid that picks up the balance. So——

Mr. GANSKE. Well, if for instance you had a provision in there that said that the supplemental could not pick up that co-payment.

Ms. RUIZ. Well, that would certainly make a difference if a supplemental could not pick up the payment. I am not sure about the issues surrounding that kind of a provision.

Mr. GANSKE. The reasoning for it is to establish some type of personal responsibility.

Ms. RUIZ. Right, I understand.

Mr. GANSKE. In Medicaid in the State of Iowa a number of years ago, we had a $1 co-payment. And I frequently had patients that came in with cigarettes rolled up in their shirt sleeves that cost more than that and also that had great big convenience store sodas that cost $1.50. And, the fact that they had to just pay something made some difference in terms of over-utilization of services for a cold, whatever.

Ms. RUIZ. We have co-payments for other services and many of those co-payments are picked up by Medicare supplemental payments, so, you know, there is a policy issue involving whether you wish to exclude some. I certainly recognize that the idea is to try to make the beneficiary accountable. If it is a really small co-payment, I am not sure that you are really making beneficiaries accountable, and it is probably individuals who can least afford it who also do not have the insurance. Therefore, I am not really sure that there is a nice black and white answer for this. I think it is something that there will be a lot of dialog about, and I think that a lot of thought needs to be put into whether a co-payment is really the answer to making beneficiaries accountable.

Mr. GANSKE. Do you think a co-payment for physician services makes a difference in terms of utilization?

Ms. RUIZ. I am not sure that HCFA could say that we have data that supports this position.

Mr. GANSKE. Now, you know when a patient gets a bill that they're partially responsible for, that isn't just sent in to HCFA, I can tell you from personal experience that they tend to look at that a little more closely.

Ms. RUIZ. However, that is where their Medicare supplemental is frequently paying for the co-payment. Therefore, I am just not sure that I have a really good answer for you, Dr. Ganske. I believe that there are arguments on both sides of the issue.

Mr. GANSKE. Do you think that if, for instances, that were covered by the supplemental that their Medigap policy would tend to look at that bill closely and assist HCFA in terms of the fraud?

Ms. RUIZ. Yes; and in fact, I believe that is an issue that we need to be addressing more seriously than we are today. This would involve working together with the Medicare supplemental companies and the Medicare fraud and abuse units to make sure that we are considering the service in total.

Mr. GANSKE. I realize that Medicare is administered by various organizations around the country, and that the HCFA organization is actually small compared to who you contract with, but would this not be a way that you could enlist a lot of support in terms of the home health care fraud, if in fact you had bills scrutinized by those private companies?

Ms. RUIZ. Certainly. We always welcome the cooperation and the assistance of the private insurance.

Mr. BARTON. You can ask one or two more questions, Dr. Ganske, if you want to.

Mr. GANSKE. Well, Mr. Chairman, I think those are the issues. I mean, when we look at the home health care fraud problem, what we've had is an open-ended system—bills submitted, bills paid, not enough oversight. We haven't had any incentive for the beneficiaries themselves to question fraudulent activities or activities that are just off the wall. And, I think to handle this, we're going down the course of a prospective payment system, so be it. I hope it works. I think that in addition to that we probably ought to look at a co-payment as at least a way to bolster the antifraud provisions of the prospective payment system. That's my own personal feeling on this and it will be very interesting to see how the Medicare Commission looks at this issue.

I yield back.

Mr. BARTON. Well, the chairman intends to work in a cooperative fashion with the administration, and we're going to monitor and be implementing and developing some goals and some plans and we're going to put everything on the table. I don't know what's going to result from that, but this is not a hearing that we're just going to say we did a hearing and we'll come back next year and do another hearing. I mean, we're going to be interactive on a continuing basis with HCFA and HHS over the next 6 months to a year.

Mr. GANSKE. So, Mr. Chairman, I'm awfully glad we're doing this because there are some other provisions in the Medicare bill that we passed that this committee should maintain some ongoing oversight on and I'm sure that Members from the other side have some other issues, too, that we need to keep track of how the Health Care Financing Commission is fulfilling their directives from Congress. One example would be a practice expense issue and what's ongoing with that as well. I appreciate your interest in this.

Mr. BARTON. We're going to be very interactive. Obviously, we're going to have to involve the Health and Environment Subcommittee chairman and ranking member, so it's not just going to be the Oversight Subcommittee. We're going to do this one the right way, in the best history of this subcommittee.

The chairman recognizes Mr. Klink for 10 minutes.

Mr. KLINK. Thank you for you're statements, Mr. Chairman. I commend you on moving forward.

This is an issue that I have been waiting to get my teeth into. I've had discussions with Dr. Coburn, yourself, and Dr. Ganske and others, and some folks on our side.

Let me just tell you something. We've had—I've started, actually—I can't call them hearings—but I've actually started holding information sessions—gathering sessions—with a stenographer, in my own district, because this—both parties have walked away from, in large part, reforming our health care delivery system. And hopefully, this will be the start to begin with how we can repair this portion of it which I think drives a lot of the rest of the health care delivery system.

We had a gentleman who was on Medicare testify—and I've got names, and we've got the actual recorded testimony. My point with what I am about to say is that we're concentrating right now on the dollars that are being milked out of the system. We're not concentrating on the fact that that that's much fewer dollars that we then have to spend to treat people who need the treatment. So we throw people out of the hospital earlier; we don't give home health care visits to people who need it.

A prime example is a gentleman who was, I would guess, in his seventies. He said he was in Medicare. He and his wife were in a car accident. He was injured to the point where he could not walk. And he had the bones in his face broken. He went to one of the best and largest regional hospitals in western Pennsylvania. They couldn't determine immediately what the course of treatment was and so they were forced to—under utilization review, we're still investigating it—they dismissed him from the hospital on a stretcher in an ambulance—can't walk, bones in his face are broken, but they can't keep him in the hospital. So they took him home. Now,

who's there to take care of him but his wife who was also in the accident. Now, eventually, he got home health care, but it was only somebody that came out to ask him some questions. He did not qualify, or was unable to get a home health care visit. They then took him back to the hospital in an ambulance. Now, HCFA and Medicare did not cover the ambulance, by the way; he's supposed to pay this out of his own pocket.

You know, we tell these anecdotal stories. I thought this was a rare story until two ladies that work for other hospitals in utilization review said, "Congressman Klink, we had not intended to speak, but we see cases like this every week to one extent or another." This is not an unusual circumstance.

Part of what we've got to do with dealing with waste, and fraud, and abuse, is to try to figure out how we can use those dollars in the direction that we actually need to have them going.

Now, I've got just a limited amount of time, I've got a lot of territory I want to cover, so let me just get away from my point for a time.

We're going to have some folks, I would guess, on the second panel, who will question the legal authority with which the moratorium is put in place, I would imagine. In anticipation of that, let me just ask you: we had received, and I would ask unanimous consent, Mr. Chairman, to submit for the record, two documents: one is an e-mail which was provided, I understand, to the committee. This is dated 8–14–1997, from J. Golland to HCFA, SMTP Gateway, which we are told is the legal authority—this e-mail represents the legal authority—with which this moratorium was put into place. And I would simply ask you, Ms. Ruiz, or counsel, I understand is with you.

Mr. BARTON. Without objection. Because I was going to ask the same unanimous consent request. And, I believe there are two e-mails.

[The information referred to follows:]

From: <jgolland@os.dhhs.gov>
To: HCFA.SMTP_Gateway("rlanders@os.dhhs.gov")
Date: 8/14/97 12:20pm
Subject: Moratoriuim on HHAs

Before I left town for two weeks, I thought it might be useful to share with you the legal advice we have provided to HCFA as it tries to find a way to respond positively to White House desires to impose a moratorium on the certification of home health agencies for the Medicare program. We were first approached last week with the moratorium idea and, at first, we were somewhat skeptical because of the potential barrier raised by section 1866(a) of the Act. This section provides that an entity seeking a provider agreement "shall" be issued one as long as it is in compliance with applicable federal requirements. Thus, a prospective HHA claiming that it meets all conditions of participation under section 1891 and 42 C.F.R. Part 484, and the provider agreement requirements of section 1866 and 42 C.F.R. Part 489, could reasonably argue that it is "entitled" to a provider agreement, and any attempt by the Secretary to deny that opportunity could be redressable by mandamus. This struck us to be the case particularly where the only announced reason for a moratorium might be that there are already too many HHAs in the program.

Since that time, we have had the opportunity to discuss the issue further with HCFA and to look more closely at the statute, and believe now that a basis exists to support a moratorium. We suggested to HCFA, first, that it would significantly strengthen its position were it to view a moratorium as a temporary measure during which time it would be devising means of better screening prospective applicant HHAs. HCFA could take the view, we concluded, that under its current procedures there were elements that, if improved, could better safeguard the program from the kind of unworthy participants that were depriving the program of needed resources as well as

depriving beneficiaries of the kind of high quality care that the statute promises. Thus, if HCFA needed time to strengthen its enrollment requirements, or possibly strengthen its conditions of participation, it could delay the issuance of new provider agreements until the new measures were in place.

Our legal analysis was based on the following:

1. While section 1866 does require that qualified providers seeking [redacted] participation be issued a provider agreement, it does not set out any time limits on the Secretary as to how quickly she must respond to these requests.

2. Section 1891(b) provides that: "It is the duty and responsibility of the Secretary to assure that [HHA requirements] and the enforcement of [these requirements] are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient use of public moneys." We believe that this section provides authority for the Secretary to take necessary steps to assure not only quality care, but the fiscal reliability of providers as well which, in this case, might best be served by a temporary moratorium on the certification of new providers.

3. We have stressed to HCFA that it would be wise to premise any moratorium on whatever facts it might have (e.g., OIG reports) to bolster its position that HHA fraud and abuse is a pressing problem for the agency and that it requires immediate and aggessive steps to assure health and safety as well as confidence in provider fiscal accountability. (Indeed, we have suggested that the better the case it is able to make in this regard, the better its chances to establish "good cause" under the APA if it were to decide that it needed to publish rules quickly to achieve its objectives.) We have also stressed to HCFA that its case may be strengthened if it could argue that any moratorium would not create an access problem for beneficiaries.

Please let us know if you have any questions.

CC: BALT3.CO3(LRuiz),HCFA.HHS_Gateway(RJaye99,HGoldber...

Mr. KLINK. There actually is. I think I want to get to—well, I have another, I don't think it's an e-mail, I have another—but I'll get to this later on.

Is this, in fact, the legal authority that you would cite in imposing the moratorium? I'm not saying the moratorium is a bad idea. I'm just asking about why it's deemed to be that you legally can do it. Or has the General Counsel's office provided some other documentation or another written opinion?

Ms. RUIZ. The answer to the first question is: yes; this is the legal authority we would cite. And the answer to the second——

Mr. KLINK. This e-mail would be the authority?

Ms. RUIZ. Well, the statutory cites contained therein would be the legal authority.

Mr. KLINK. Contained there in this e-mail? So nothing separate. There's no separate other—you've issued a moratorium and there was nothing—this was not important enough to go out and to create a separate legal document that said, that cited these authorities? So, we're having a moratorium on allowing more people to get into this home health care delivery system and this is the only document, to your knowledge, that HCFA has generated?

Ms. RUIZ. Yes, it is the only document. I guess I would suggest that I do not believe that the absence or presence of a formal opinion is an indication of the level of importance that HCFA would place on these actions.

Mr. KLINK. Well, let me just ask you for a second—I'd also asked, Mr. Chairman, unanimous consent for a document dated 8–22–1997, which would be about a week and a day later, from Thomas Hoyer to you and to K. King, L. E. Shannahan, and D. Chang. And, in that document it says, in the third paragraph down, I'll just read it to you, it says: "Although the full range of internal views is not stated in the official comments, staff felt that a broad moratorium would be indefensible legally and that the OIG should recommend something more specific as noted in this report numbered and titled as above has been issued."

Mr. BARTON. Without objection.

[The information referred to follows:]

From: Thomas Hoyer
To: KKingl,EShannahan,DChang,I.Ruiz
Date: 8/22/97 1:37pm
Subject: Home Health OIG- Moratorium -Reply

Now that a moratorium of the certification of HHAs is a real probability, I wanted to send you all a "Heads Up" reminder that HCFA did officially nonconcur in an OIG report recommending a moratorium.

We now have the final report for review and we will make additional comments relating to provisions of the BBA and whatever actions are decided in connection with the moratorium; however, the final report currently exists and you should be aware of it.

BACKGROUND

The OIG Final Report "Home Health: Problem Providers and Their Impact on Medicare" (OEI-09-96-00110) was sent to HCFA by June Gibbs Brown for comment in a memo dated July 28, 1997. HCFA had commented on the draft report and nonconcurred on the OIG recommendation for a moratorium on certification of HHAs. The HCFA comments were published as part of the final report published in July 1997. Although the full range of internal views is not stated in the official comments, staff felt that a broad moratorium would be indefensible legally and that the OIG should recommend something more specific. As noted, this report, numbered and titled as above, has been issued.

In reviewing the final report, we can make additional comments. Initially, we plan to note that some of the OIG recommendations have been under review since the final report was issued in July. Since this is highly sensitive, we do not plan to forward the comments to the OIG until the Secretary makes a decision on a moratorium for HHAs or other requirements.

The COO staffer who is collecting comments on this final report is Robin Magwood at x 61999. The CHPP staffer who has the background is Susan Levy at x 69364.

Please let me know if you need more information.

CC: BALT2.CO2(jflaherty), BWardwell,SLevy,BWynn,KButo,...

Mr. KLINK. I'm confused.

Ms. RUIZ. Well, Mr. Hoyer is not a lawyer. Mr. Hoyer is one of our policy people, and it is his staff who I think were primarily responsible for the initial HCFA reaction to the IG's recommendation. What you see in his e-mail is reflective of what I said earlier. This is the sort of traditional conservative approach that HCFA has taken, and it was essentially written and believed without benefit of discussion with the Office of General Counsel.

Mr. KLINK. Well, then, Ms. Ruiz, why did HCFA not originally accept the IG's suggestion that this moratorium occur?

Ms. RUIZ. I think because we were very concerned about whether that was the appropriate—it was a drastic action, and there are ramifications. We recognize that there are ramifications to a moratorium. I am not here today to say that there are no ramifications. If there were no ramifications, there would have been no point in doing it. And, so, I believe that what we are saying is that our traditional approach has been to make it possible for everybody to enter the program. This is what the statute contemplates in many ways, and we are trying to provide access to a lot of people. HCFA has traditionally taken this approach. What we are saying is that it was time for us to sit back and say: is that really all the statute requires? Or is there also a responsibility on HCFA's part to make sure that the people who are coming into the program really deserve to be there? This is what we did, and that was part of the discussion involving the moratorium.

Mr. KLINK. I'm sorry I missed the beginning of—I read your testimony, I didn't hear what you had to say today. Do you have any problem with the 40 percent figure in the four-State study that the OIG did?

Ms. RUIZ. Do I have any problem?

Mr. KLINK. Do you agree, disagree?

Ms. RUIZ. If I believe that it's accurate?

Mr. KLINK. Yes.

Ms. RUIZ. Yes, I do. I have no reason to quarrel with the IG sample—either the methodology or the results. We are very concerned about——

Mr. KLINK. Does that mean the program is out of control? Do you agree with that assertion by the IG's office?

Ms. RUIZ. I am not a person given to hyperbole, so you will not see me saying that the program is out of control. However, I believe that we have a very serious problem.

Mr. KLINK. So, what I'm concerned about: are you telling us now, and I'm going back to Dr. Ganske's question I think, do you think that the time period of 1999 to get to the prospective payment system for home health care is doable?

Ms. RUIZ. I believe that HCFA would not have agreed if the agency did not believe that it had some possibility of meeting the deadline. I think that they also believe that——

Mr. KLINK. Some possibility. Small possibility? Large possibility? Reasonable possibility? What possibility?

Ms. RUIZ. That is difficult for me personally to say. HCFA believes that this is a very aggressive schedule, and the agency is working very hard to meet it. However, we are not sure that HCFA

will meet it. And, if we do not think we can, we will be back here to tell you so.

Mr. KLINK. Can I ask unanimous consent for 2 additional minutes, Mr. Chairman?

Mr. BARTON. Without objection.

Mr. KLINK. Thank you.

Can you give us an idea, then, how are you going to reach this one? Tell me what the milestones are. How does this subcommittee know what those milestones are? And, how will we know when you've hit each milestone and the time line that you hit that milestone?

Ms. RUIZ. Mr. Klink, if I could do this: there is a time line. And, if you would consent, we would be happy to submit that for the record.

[The following was received for the record:]

SUMMARY—OPERATIONAL/POLICY TIMELINE FOR HOME HEALTH PPS (10/1/99)

JANUARY 1998

- Interim findings from the National Home Health PPS Demonstration, Phase II are providing information to evaluate and develop a home health episode period. Interim findings from the Volume/Outcome study, available winter 1998, will provide information the amount and range of services that is most beneficial to patients. Analyze interim findings—episode data and volume/outcome study. Develop approach.
- Analysis of episode database
  - —The studies indicated above will provide information on: 1) the impact of per-episode prospective rates on the use and cost of home health services, access to care, quality of care, and use and cost of other Medicare services and 2) whether lower and upper thresholds exist below and above which home health does not contribute to better patient outcomes for 4 common home health conditions (stroke, congestive heart failure, surgical hip procedures, and open wounds)
- Determine the appropriate episode for PPS, based on interim findings.

Operations:

- Begin development of systems and operational specifications on episode periods and breaks in service.

Regulations:

- HHA PPS Regulation: Begin to develop regulation specifications regarding the episode period based on these recommendations.

JUNE 1998

- Interim findings on case mix from 1) Phase II PPS Demonstration and 2) Case Mix Study
  - —The studies indicated above will provide information on: 1) home health resource utilization, including information on the length of all home health visits provided to a cohort of patients and information on the procedures performed during the visits based on the first 6 months of data collection, and 2) data items on the Outcomes Assessment Information Set (OASIS) that can also be used for case-mix adjustment and additional, needed items.

Operations:

- Detemine billing specifications and systems specifications to operationalize findings.

Regulations:

- HHA PPS Regulation: Begin to develop regulation specifications on case mix adjustment.
- OASIS Regulation: Publication date for interim final regulation governing national OASIS reporting requirements as a condition of participation for home health agencies.

JANUARY 1999

- Final case mix adjustment recommendations from case mix study.
- Evaluation contractor will make available supplemental analysis in addition to PPS Phase II interim findings. Based on this additional information: refine case mix adjustment and episode definition
  —From this additional information we have more information of the same nature, but in more depth than the findings in June 1998.

MARCH 1999

- Interim final PPS regulations specifications developed.

JULY 1, 1999

- Publish Interim Final PPS regulation.

Mr. BARTON. We'd very much appreciate that.

Ms. RUIZ. Okay.

Mr. KLINK. Describe for me, in as general a terms as you can, what is included on that time line.

Ms. RUIZ. I am afraid that I am not in the best position to do that, this morning. I apologize.

Mr. KLINK. Well, what does that time line do. If we get that time line, you see, I've just asked you a very specific question, and one that's very important to us, one that means billions of dollars in cost savings and being able to take care of people's lives. And, you tell me that you've got a document that's not in this room, and I'm supposed to accept that and yield back my time. And, I'm not doing that. What will we see, when we see this time line? How will I know whether you've hit your goals or not? You can't tell me that?

Ms. RUIZ. I am unable to personally tell you that today, sir.

Mr. KLINK. Who can tell me that? Is there someone in this room that can tell me that?

Ms. RUIZ. I do not believe there is anyone in this room who can say that, today.

Mr. BARTON. But the document does exist?

Ms. RUIZ. The document does exist, yes.

Mr. BARTON. And, you've read the document?

Ms. RUIZ. I have not, personally, read it.

Mr. BARTON. You've not personally read it?

Ms. RUIZ. I know that there is a time line, and——

Mr. KLINK. Why would you think, Ms. Ruiz, that—if you'll just yield for a moment, or suspend for a moment—why would think that that time line might help this subcommittee to do its work, if you haven't read it?

Ms. RUIZ. Well, I have to say, I am the representative for all of HCFA today. As I prepared for this hearing, I discussed it with HCFA's staff responsible for policy and implementing PPS. I was informed that HCFA has a time line and is prepared to submit it.

Mr. KLINK. Okay. Let me ask you a question. You're title is Director of Program Integrity?

Ms. RUIZ. Yes, sir.

Mr. KLINK. The question I'm asking you is directly relating to program integrity. How do I know that your program has integrity? How do I know that you're going to be able to meet these deadlines on a specific time line? How will this subcommittee know that you're going to meet these milestones in a timely fashion, and what those timeframes are? Do you believe, from what you've been told,

that there will be, on this time line, actual dates? Let's start with that.

Ms. RUIZ. You have me at a disadvantage.

Mr. KLINK. You have me at a disadvantage. Because I'm trying to determine at this hearing whether or not we have a grasp on moving forward to this prospective payment system. And, I assume that when the majority spoke to you and told you about this hearing, the people at HCFA knew what material was going to be covered and that there would have been some attempt by them to inform you, as the representative of HCFA, or the counsel, or whoever else was here, about the matters that might come up.

We've got a problem here with the IG's office saying that 40 percent of the money that's being paid out for home health care visits, there's a problem with it. It's incorrect, in some form or level. We've got to correct that. The suggestion is that you're going to go to prospective payment system. You're going to do it by 1999. I remind you that we had a hearing a couple of weeks ago where we were told that you spent $45 million, or some similar figure, on trying to get a computer program together with GTE to handle the waste, fraud, and abuse, and now we don't know what we're going to get from that program. We don't know if we're going to be able to—the taxpayers can keep that software. We don't know how much of that money is wasted. We don't know how much of it is going—we were told here, that those negotiations were still going on, but trust us, the agency is saying, we'll get back to you.

Now, we've got the same kind of a situation here, and I'm bothered, because again, we're talking billions of dollars, and ability or inability to deliver home health care, in this instance, to the people of my district, Congressman Barton's district, everybody else's district, and you can't tell us how we will know from this date forward whether or not you're on a time line to hit those——

Ms. RUIZ. I am truly not asking you to trust me. I am simply saying that my responsibility does not cover the prospective payment system; I do not consider myself an expert in this area. We do have a time line which we will be happy to submit for the record. We will be happy to work with you and your staff, if you feel that there are things missing that should be included in the time line.

Mr. BARTON. We're going to hold you to that.

Now, the Chair wants to inform Mr. Klink, that you and I both have got, officially, 3 minutes to make this vote. I would recommend that we suspend. You and I go vote. As soon as Dr. Coburn gets back, he will begin to ask his questions. By that time, you and I should be back and if we've got wrap-up questions for this witness, we'll do that.

Mr. KLINK. That's good.

Mr. BARTON. So, I'm going to suspend the hearing until Dr. Coburn returns. When Dr. Coburn returns, he will begin to ask you his 10 minutes.

Ms. RUIZ. Alright.

Mr. BARTON. And by that time, I'll be back.

Ms. RUIZ. Okay.

Mr. BARTON. We're in recess, subject to Dr. Coburn coming back to ask his questions.

[Brief recess.]

Mr. STUPAK. [presiding] While we're assuming the Chair and waiting for others to come back, let me ask a few questions, if I may.

Ms. RUIZ. Okay.

Mr. STUPAK. I apologize for being a little late on your testimony, but I did read it. And, when I came back, you were sort of having a discussion with Chairman Barton on this 40 percent error rate—OIG calls it an error rate, you want to use some other number? And I guess I'm——

Ms. RUIZ. No. Actually, these are two different things. That is really my point, Mr. Stupak. We worked with the Office of Inspector General in fiscal year 1996 to perform an audit of all services except durable medical equipment to determine an error rate. It was performed pursuant to the Chief Financial Officers Act. The audit created an error rate of 14 percent. That is a separate, much more comprehensive study and sample than the one that the IG did in their study specifically on home health. Therefore, these studies involve two separate, and in many ways, unrelated, numbers.

Mr. STUPAK. Unrelated, but you don't dispute the fact that there is probably a 40 percent in the Medicare home health?

Ms. RUIZ. No, sir; we do not dispute that.

Mr. STUPAK. You were here earlier, I believe, when we had the previous panel.

Ms. RUIZ. Yes.

Mr. STUPAK. We talked a little bit about three different provisions, or I think the consensus being formed by the committee is that we have to take a look at the definition of home health; we have to give law enforcement the tools; and also you need the resources in order to cut down on fraud, waste, and abuse in the home health area. Is there anything we are missing in that three-prong attack?

Ms. RUIZ. You mean, do we need more prongs? I certainly need—I need to be sure, and I believe that this is Mr. Barton's point, and I am unable to dispute it in any way. We are maximizing the use of our resources to focus on appropriate things and to use the right tools. There is no formula for fighting fraud and abuse. There is nobody that I know of that could tell me: if you do X, Y, and Z, you will succeed. This is something that all of us are learning together. Nobody has a copyright on how to accomplish this task. We believe that the four prongs that I mentioned are the right approach. I do not know that I could say that there is a prong missing. There are tools that support these prongs, such as technology.

Mr. STUPAK. But our concern, from sitting up here, and maybe our frustration is: there may be all these prongs, but there's no coordination, there's no comprehensive addressing of the issue. We see this stuff go on, and whether it's Congressman Klink's story, or Dr. Coburn, what occurred in his district, we see it day in and day out, and there's no coordinated effort here.

Ms. RUIZ. Well, I think there is more of a coordinated effort than you would believe. And, actually——

Mr. STUPAK. Well, make us a believer. Tell us.

Ms. RUIZ. The problem provider report is a result of coordination between HCFA and the Office of Inspector General. That is how these providers were identified.

Mr. STUPAK. Doesn't HCFA, in the statute that's created Medicare and all that, don't you have something called "inherent reasonableness?"

Ms. RUIZ. Yes.

Mr. STUPAK. How come you never use it.

Ms. RUIZ. We actually did use it for oxygen. I do not know if you are aware of the long and painful history of trying to actually implement an inherent reasonableness for oxygen, but it has been a very difficult process.

Mr. STUPAK. Well, oxygen's been one, but I know, myself, and I know other Members have brought up this inherent reasonableness, and while you admit that it exists, nobody wants to utilize it.

Ms. RUIZ. I believe that we do wish to utilize it. I think HCFA's position——

Mr. STUPAK. In the 5 years I've been here, I haven't seen anyone want to use it yet.

Ms. RUIZ. I actually think that this administration has wanted to use it and that is why they applied it to oxygen. It is a difficult tool to use, or it has been, because it requires a lot of underlying data. The data is always subject to dispute and that is part of what happened with oxygen.

Mr. STUPAK. But, see—and, I guess, maybe it's going back to what I was saying in the first part—we always wait until the problem gets so complex and compound and feeds on itself, that we come in here with some half-hearted solution when we have the inherent reasonableness standard or procedure right there, but no one wants to take the bull by the horns, if you will, and get at this.

And, I guess that's the frustration that we see from this side of the dias. And I think that's some of the frustration you're seeing here today.

Ms. RUIZ. Yes. I think that probably—you would also see a lot of frustration in HCFA about how to use that tool properly. You may be misinterpreting that to mean that we do not wish to use it.

Mr. STUPAK. But if HCFA has the frustration within its agency, what does that frustration stem from then? If we're frustrated and you're frustrated then where is the breakdown?

Ms. RUIZ. I have to say that my understanding of the inherent reasonableness tool has been that it was too complicated to actually become a timely and useful tool, and that was one of the concerns. I believe that there has been a lot of discussion in the past about how to make this tool more useable.

Mr. STUPAK. I can see Dr. Coburn is dying to jump in. I'll yield to the gentleman.

Mr. COBURN. Thank you.

You know, I just find it amusing that the tool that the Congress decided to give HCFA to help it unwind problems is now too complicated of a tool to unwind the problems.

The first hearing that I came to as a Member of Congress was the Inspector General telling us about the waste, fraud, and abuse

of Medicare, and that was in February 1995. And HCFA, at that time, you're former boss, talked about how they couldn't correlate at that time, the relative rates of fraud. We're 2½ years later and you come before us and say, "We can't correlate."You know, you probably expected me to be really upset with you about that statement. But I'm not. Because I think the system is so broken that we could triple your budget and we could triple the number of people, and I still don't think you could correlate it. Because, you know, there's only one thing worse than the IRS tax code in this country, and it's HCFA regulations and rules. And, you know, that may not be a fair statement by your assessment, but it certainly is for the people who have to live under them and don't know whether or not their going to be treated fairly when they, under their own intention, trying to do things right, and you can't understand what the rules and regulations are. You don't know whether you're defrauding or not, because it's not clear. And, it's intentionally not clear because the system's intentionally not clear.

You said that there is no formula for waste, fraud, and abuse. And I disagree with that. I think there is a great formula, and that is: it's called KIS: keep it simple. And that's what the military does, and that's what we need to do in health care. And we've not done that. What we've said is: we're going to have anything except simple. What are the numbers of the pages of regulations that HCFA has printed in the last 10 years in this country?

Ms. RUIZ. I could not tell you.

Mr. COBURN. Yeah, I can tell you it's about this thick, and that if you want to stay out of trouble with HCFA, then you'd better know what those are, and you also better understand what the mood of the person is that's interpreting them at the time.

You know, we're saying there is $23 billion, and that's a conservative estimate, of the fraud. And you're trying to lower it from 14 percent to 10 percent, which I think is, you know, if you can cut a third of it, that's really talking about reducing fraud 33 percent over the next 5 years, that's really what you were trying to say, I believe?

Ms. RUIZ. Yes.

Mr. COBURN. But a large portion of that fraud, a third of it, is in home health care. And I know that. You all obviously, you've said you don't know where it is, but I know that's where it is, and I think that's where the Inspector General thinks a good portion of it is. Is it wrong for us to ask the following two questions: what are you going to do about that, one? Or what should we change, in terms of the regulations for home health care, to where it's not so easily defrauded and you don't have to spend so much time trying to find out where the fraud is? What are those two things? What can we do?

Ms. RUIZ. Well, I think that HCFA's announcement of the moratorium in September with the assistance of the Department and the administration is a step in the right direction. It is not a panacea. However, we considered all of the problems and stated: what are the things that we are currently doing and what are the things that still need to be done? One of the big gaps that we recognized involved how easy it was to become a provider. Therefore, many of the tools that we are presently engaged in fixing are tools to make

it harder to become a Medicare provider of home health so that we can really be sure that individuals who do enter as providers are able, financially and staff-wise, to provide proper services. We also wish to prevent providers from using the Medicare program as a self-help program for entrepreneurship. I believe this is a step in the right direction.

Mr. COBURN. Is that happening now, in your opinion?

Ms. RUIZ. Yes.

Mr. COBURN. How long has it been happening?

Ms. RUIZ. Well, I believe it has been increasing every year. I mean, we have seen——

Mr. COBURN. But how long have we utilized the Medicare system as a self-help system for our entrepreneurship in this country?

Ms. RUIZ. For home health, probably ever since we began to expand the benefit.

Mr. COBURN. And, how long has that been?

Ms. RUIZ. Well, we have witnessed a significant growth start beginning about 1990.

Mr. COBURN. So, if we knew that, why is it 1997, and we're just now starting to ask the questions of how we change the program so its not that.

Ms. RUIZ. We are not just starting. We actually started in 1993 with the Administrator's Home Health Initiative. It was a very big initiative for the agency. We convened individuals representing the home health industry, law enforcement, medicine, and the American Medical Association. We convened a variety of different participants and we conducted many studies.

Mr. COBURN. So the implication is that the fraud was greater in 1993 than it is in 1997?

Ms. RUIZ. No. However, we witnessed the growth in the benefit and the problems that were existing and stated: we need to decide what we are going to do about it. As a result of that initiative, we made many recommendations, many of which ended up in the President's bill and became law in the Balance Budget Act. Therefore, I believe that we have been working on this for some time.

Mr. COBURN. You know, if I were to tell my district that it takes 4½ years to look at a problem and then implement a change for a problem, they would say let's clean the whole place out. Let's clean the Congressmen out, let's clean the bureaucrats out, and let's start over. And you know, maybe that's what we need to do in terms of Medicare home health.

Have you all thought about just saying: let's think out of the box for a minute. We have these seniors that we want to make sure we take care of. Here's our goal. Is there another way that we can do this that gets rid of all these complicated regulations, gets rid of all these complicated rules, it's not designed to set up to enrich people who are very adept at entrepreneurship? Have you all ever sat down inside your group and said, you know: What could we tell the President to tell the Congress to do to change all this.

Ms. RUIZ. Are you talking about redesigning the benefits?

Mr. COBURN. I'm talking about changing home health care.

Mr. STUPAK. The whole system is what he's talking about.

Mr. COBURN. [continuing] Saying: here's our goal; here's how much money we've got; is there a better way of doing it? Has any-

body inside HCFA said that? Or are you lost in the forest of the trees trying to keep track of everything we're trying to ask you to do? And if you haven't sat down, why haven't you sat down? Since you all obviously know this system better than anybody else, why haven't you sat down and said, "Mr. President, we think this whole thing ought to be changed this way to make sure people get the benefits that they deserve and the tax payers get the efficiencies that they deserve"?

Ms. RUIZ. I actually believe that this was the major intent of the Home Health Initiative. It involved carefully reviewing the benefit and asking, "what do we need to do to ensure that it will be able to serve people better, and at the same time, to ensure that we are not wasting money?" Perhaps, we did not think as much out of the box as you would have liked.

Mr. COBURN. Well, my only problem with that is that we had the Inspector General saying that 40 percent of the dollars that you all are paying out for us as taxpayers to take care of our seniors are misappropriated. They should not have been paid out. So, I just have to say, we have to do a better job.

Ms. RUIZ. I don't disagree with you.

Mr. COBURN. Well, how do we do that? How do we get everybody to agree with you and me?

Ms. RUIZ. Although, I am unable to say that we are doing everything that needs to be done, I do believe that the Home Health Initiative and Operation Restore Trust are two important steps. In Operation Restore Trust, we have actually been going out to verify claims and beneficiaries eligibility. We also have partnerships with the survey and certification agencies to look at targeted——

Mr. COBURN. I agree. I wish you'd come to Oklahoma and do Operation Restore Trust. But, you're doing it in limited areas.

Ms. RUIZ. No; actually we will conduct reviews in areas which anybody wishes to work with us.

Mr. COBURN. Please come to Oklahoma.

Ms. RUIZ. If Oklahoma wants to do something, I would be happy——

Mr. COBURN. I invite you today to come to Oklahoma and rid of us of the people who are defrauding the taxpayers of this country and the seniors of the care that they deserve by stealing their money.

Ms. RUIZ. Alright.

Mr. COBURN. It's not just necessarily home health care firms, it's from physicians to hospitals. I will share with you that a hospital in my district is billing patients separately and you all are paying for an office visit, and a doctor who's under their employment using their building is billing patients for a comprehensive level 3 exam and you're paying both of them. And you know, we've turned it in, it's still getting paid. I mean, I can't do anything more as a Congressman, because I can't get HCFA to use their own rules to do it. It's a much harder animal so that the way to change it is to change the program rather than to change HCFA.

Ms. RUIZ. Well, I don't disagree with that either.

I actually believe that the identification of the level of the problem is a very important first step, because it sets a baseline. This is something that had never been done before. So——

Mr. COBURN. So, where do you think the level of the problem is, speaking for HCFA? Where's the level of the problem with home health care?

Ms. RUIZ. I want to be sure that I understand your question.

Mr. COBURN. You said, you thought a very important first step is identifying the level of the problem. Where is the problem?

Ms. RUIZ. Well, I believe that the IG study reveals that in four very large States, 40 percent of the services are not medically necessary. The study demonstrates a baseline and a level of the problem.

Mr. COBURN. Okay. So, if the problem is: 4 out of every 10 dollars that we're paying out in home health care should not be paid out, what should HCFA's response to that be? Should it be to write more rules and regulations? Or should it say: we recommend that Congress change this so that we don't have this kind of perverse incentive to take the taxpayers money.

I mean you all can write rules and regulations for the next 10 years, and it's not going to change it. All it's going to do is make it more costly to have HCFA around. And, more costly for the honest providers to meet the care and the requirements that you set forward. What I'd like to see is the administration and people in Congress stand up and say, "We've got a big problem. Let's really fix it." Let's don't play with it, and let's don't fix the wrong problem.

Ms. RUIZ. I will certainly take that message back to Ms. DeParle.

Mr. COBURN. Thank you.

Mr. STUPAK. I guess I'd have to reclaim my time and reclaim all your time and everything else, but——

Mr. BARTON. The Chair wants to announce that apparently now we're going to have a series of votes. So, I'm going to recognize Mr. Stupak for such time as he may consume, since he was kind enough to assume the Chair, and at the conclusion of his questions, if Congressman Klink has one wrap-up question, we'll recognize Mr. Klink. Then we're going to excuse this witness, recess until the series of votes is over, which will probably be about 2:30.

So, Mr. Stupak is recognized for such time as he may consume.

Mr. STUPAK. Well, thanks, Mr. Chairman.

I want to switch gears if we can. We talked a lot about fraud, waste, and abuse. We talked about the Balanced Budget Agreement, and it's my understanding that the BBA removed medipuncture as a skilled nursing procedure for homebound patients. And my district is a very rural district, very under-served; you get 40 to 60 miles to the nearest hospital, and these folks who may need this service, whether they're on anticoagulants, or insulin, or anticonvulsive medicine, whatever it might be, we're really concerned that the monthly monitoring of blood tests which is needed to receive safe care—and it's a medically necessary service—it's my understanding that that's been removed.

Ms. RUIZ. Not exactly. Let me try to clarify that for you, Mr. Stupak. You may have heard the discussion with the first panel about the fact that once a beneficiary is eligible for one service——

Mr. STUPAK. Other services——

Ms. RUIZ. [continuing] then they can get a whole range of services. One of the things that HCFA was very concerned about was

the number of homebound beneficiaries, who only really needed a monthly or periodic draw of blood in their home. However, this service permitted the home health agency to enter the beneficiary's home with home health aids and to provide many other services, which are very expensive. The law did not remove coverage for venipuncture in the home. It simply took it out of qualifying you for the whole range of home health services.

Mr. STUPAK. So you still pay for——

Ms. RUIZ. Therefore, a beneficiary can still receive payment——

Mr. STUPAK. For venipuncture.

Ms. RUIZ. [continuing] for a phlebotomist to come to their home and take their blood. They simply will not get paid for it through the home health benefit and be eligible for all the other associated services.

Mr. STUPAK. So the venipuncture would be covered, but not other services.

Mr. COBURN. Would the gentleman yield?

Ms. RUIZ. Yes.

Mr. STUPAK. And, I'll yield.

Mr. COBURN. I would just remind us to go back to what was the original intent of home health. Is how many of those people that we're spending $120 to draw their blood and then do a dilantin level, or PT, or PTT, or some other drug level—philopholin level on—how many of those people are capable of coming to a lab to get it drawn. Because that cost is about one-fifth of the cost of having a technical person go to them.

Now, those people that aren't capable of doing that, we should do that for them. But that's where the difference lies. We can wrestle about all these all we want. But until we get down to defining whose homebound; it gets right back to the same thing: who do we want to get these services? And then those who should be getting the service, we should make sure that they get every service they need. And what has happened is, people who shouldn't be getting services are taking away the availability of services for people who should be. And that's our problem.

Mr. STUPAK. Well, that's all fine, but, you also understand, and I know you do, because I know you have part of it in your district, my district is basically under-served areas where if you're going to go somewhere to get one of these, it's 45, 60 miles one way, and it's probably cheeper to have them come to the home to do it as opposed to having these people travel. I mean, last week we had nine inches of snow, and it's just beginning.

Ms. RUIZ. We will pay for a phlebotomist to come to their home.

Mr. STUPAK. Sure.

Ms. RUIZ. And if time shows us that there——

Mr. STUPAK. But the expansion of the services will no longer be paid for. That's what you're trying to say.

Ms. RUIZ. That is right. What we are trying to limit it so that beneficiaries will receive the service they need and no more.

Mr. STUPAK. I have no problem with that. Thank you.

Mr. BARTON. Does that conclude your questions?

Mr. STUPAK. It concludes. Thank you, Mr. Chairman. And I'm going to go vote.

Mr. BARTON. Okay, does anybody have one final question? I think Mr. Klink had a final question, and then I'll give Dr. Coburn a final question. But we've got about 8 minutes left officially in this vote, and then there are 3 more votes after that vote.

Mr. KLINK. Before I ask my question, I'll ask another question. Ms. Ruiz, is it possible that someone can stay from HCFA to hear the third panel in case there are some questions that come up?

Ms. RUIZ. Actually——

Mr. KLINK. I'm not asking you personally, but if someone can be here?

Ms. RUIZ. Yes, we had intended that someone would stay, but I think it was more of a legislative staffer so that I am not sure that they would be prepared to answer questions.

Mr. KLINK. What I'm concerned about is that there are going to be, I think, some accusations made that some market approach to catching waste, fraud, and abuse had been suggested and that HCFA hadn't done this. I don't have time to get into this now, but we'd like the agency to be able to respond. That's all.

My final question is, and I think I alluded to this in my opening statement: back during the 1980's, you had fiscal intermediaries that were auditing about half of the claims, and that's now down to about 1 or 2 percent, which would mean that 98, 99 percent of the claims are not being audited. That seems to send an awful signal to those that would have larceny in their hearts.

Ms. RUIZ. We agree. I believe that what you witnessed involved a huge increase in services and the number of providers. There was also a decrease in resources that were available. Therefore, HCFA could no longer keep up with the level of service through audits. We believe that the level that is currently being performed is unacceptable, and we are trying to increase it by increasing the amount of resources available in the Medicare integrity program's funding.

Mr. KLINK. Thank you, Mr. Chairman, I yield back the balance of my time.

Mr. BARTON. Dr. Coburn, one last question.

Mr. COBURN. Is there a diabetic in this country that I couldn't get on home health care if I wanted to?

Ms. RUIZ. Probably not.

Mr. COBURN. That's what's wrong with the program.

Mr. BARTON. Is that you're question?

Mr. COBURN. That's my question.

Mr. BARTON. Okay.

We're going to excuse you. We know you're not the political appointee that's supposed to head the agency. But, when you go back, please tell the acting head, who we hope will be confirmed, that we're going to be interactive, we're going to be requesting some follow-up, personal meetings within the month.

Ms. RUIZ. I understand; and thank you for your patience.

Mr. BARTON. Thank you.

Okay, the Chair wants to announce we have one more panel of home health care practitioners. We're going to recess until approximately 2:35 because we have this vote and then three other votes so I don't see how we can get a quorum back here until 2:35. So, if our final panel will be patient, we'll reconvene at 2:35.

We're in recess until that time.

[Brief recess.]

Mr. BARTON. My apologies for being about 20 minutes later than I said.

We do have one more panel. Last, but not least, we do have representatives of the home health care industry. If you all are here, ladies and gentlemen, we'll reconvene.

I'm going to give the usual caveats: we do ask that you testify under oath. Are all four of you willing to do that?

Mr. CENAC. Yes.

Mr. PYLES. Yes.

Ms. RAPHAEL. Yes.

Ms. SUTHER. Yes.

Mr. BARTON. You also do have the right to be advised by counsel. Does anybody have a counsel here that needs to be sworn in also?

[No response.]

Mr. BARTON. Okay.

Will each of you please stand and raise you're right hand.

[Witnesses sworn.]

Mr. BARTON. We have on our third panel Mr. Dwight Cenac, chairman of the board of Home Health Care Association of America. We have Mr. James Pyles, whose with Powers, Pyles, Sutter and Verville, representing the Home Health Services and Staffing Association. We have Mrs. Carol Raphael, president and chief executive officer, Visiting Nurse Service of New York. And we have Mrs. Mary Suther, is that correct?

Ms. SUTHER. Right.

Mr. BARTON. Who's the chief executive officer for the Visiting Nurse Association of Texas, Chairman of the National Association for Home Health Care.

Each of your statements will be included in their entirety in the record and we're going to ask that you summarize those in 7 minutes or less. And, we will start with Mr. Cenac and then work our way down.

TESTIMONY OF DWIGHT S. CENAC, CHAIRMAN OF THE BOARD, HOME CARE ASSOCIATION OF AMERICA; ACCOMPANIED BY JAMES C. PYLES, ON BEHALF OF HOME HEALTH SERVICES AND STAFFING ASSOCIATION; CAROL RAPHAEL, PRESIDENT AND CEO, VISITING NURSE SERVICE OF NEW YORK; AND MARY SUTHER, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Mr. CENAC. Thank you. Good afternoon, Mr. Chairman, and members of the committee.

As you said, my name is Dwight Cenac, and I'm chairman of the board of Home Care Association of America. HCAA represents over 300 free standing locally owned and operated home health agencies across the United States.

In my opinion, there are several reasons that Members of Congress have seen an increase in home health waste, fraud, and abuse. HCFA, No. 1, is preventing competition in the home care industry. I recently read a quote from Chairman Bliley where he stated, "No economist can quarrel with the notion that competition lowers prices. Competition improves productivity and monopolies are always inefficient and expensive, always." Mr. Chairman,

HCFA has prevented competition by not enforcing 42 CFR 424.22. This long-standing regulation prohibits doctors from self-referring to the hospital-owned home care agency if that doctor is compensated over $25,000 by the hospital.

Second, HCFA has inappropriately allowed hospital agencies to double dip the Medicare system for each self-referral they get. The specifics of the double dip can be found in my written testimony. This is no small issue. It is costing the Medicare program billions of dollars annually, and Columbia HCA is just the tip of the iceberg of hospitals and chains which are unethically overcharging Medicare's home health care benefit after running out of business or buying out free-standing HHAs. I have brought several charts to show this point.

HCA recommends that Congress require the President to immediately issue a moratorium on hospital chair Columbia HCA from selling off its home care operations. And if Columbia HCA is found guilty, that Congress should require that HCFA decertify all Columbia HCA home care provider numbers just as it has falsely done in the case of CSM home health care services of Los Angeles, California.

In addition, we honestly believe that HCFA, under Operation Restore Trust—ORT—in the way it surveys, it is specifically targeting free-standing home health agencies because they lack the resources to fight against HCFA; just as the IRS is seen to have targeted small businessmen and women across the country.

Mr. Chairman, one of those small businessmen who has been falsely run out of business by HCFA under ORT is Marianno Valez, of CSM. With your permission I would like him to stand for a moment.

Mr. BARTON. Without objection.

Mr. CENAC. Thank you.

HCA calls on Congress to instruct HCFA—asks Congress to instruct HCFA—to stop its double standard and be even handed in its ORT activities by expanding their audits to hospitals and large chains who overcharge Medicare billions.

Section 4312 of the Balanced Budget Act entitled, "Disclosure of Information and Surety Bonds" is very vague. HCFA must provide guidance in bond form to home health agencies immediately so that agencies can comply with the January 21, 1998 deadline. Insurance agents have told us that they are unable to offer a bond without a bond form. In addition, the bond form must clarify that HCFA can access the bond only for an agency that has filed for bankruptcy or has been indicted for fraud.

HCAA also recommends that providers which have been in existence for 3 years and which have successfully passed surveys and audits be exempted from such bonds and that the Balanced Budget provision requiring that they be re-enrolled be dropped.

HCAA recommends that Congress instruct HCFA to vigorously enforce the provision of the Balanced Budget Act protecting patients rights found in section 4321, entitled, "Non-discrimination in Post-hospital Referral to Home Health Agencies and Other Entities."

HCAA recommends that Congress investigate the legality and propriety of President Clinton issuing a moratorium on new home health agencies and HCFA implementing it.

HCAA recommends that Congress instruct HCFA to vigorously enforce 42 CFR 424.22 to honor the ruling of the administrative law judges in the case of CSM, to expand ORT and wedge surveys to hospitals and large changes, to incorporate HCAA into a task force designed to root out and stop the sophisticated health care thief.

We also ask that HCFA be instructed to expand its investigation of all agencies which in the last 6 years have entered into management contracts and all agencies which have a substantial part of their services provided by subcontract nurses.

HCAA also asks that Congress hold hearings into the abuses of Medicare intermediaries and of HCFA under ORT and the wedge survey. Many honorable home health agencies throughout the country have been abused by heavy-handed and overzealous auditors.

We also ask that Congress instruct HCFA to not deny agency reimbursement for their reasonable efforts to educate beneficiaries about eligibility requirements.

Last, Mr. Chairman, HCAA recommends that one of the most devastating provisions of the Balanced Budget Act, section 4602, pertaining to interim payments system, be modified per beneficiary cap, or to be eliminated, or to base it on 1995 data versus 1993 data. 1993 data does not accurately reflect necessary patient care levels. Additionally the hospital-owned agency per beneficiary cap must be determined from a weighted average of all non-hospital owned agencies in the area.

This concludes my verbal testimony. Thank you. And I would be happy to answer any questions.

[The prepared statement of Dwight S. Cenac follows:]

PREPARED STATEMENT OF DWIGHT S. CENAC, CHAIRMAN OF THE BOARD, HOME CARE ASSOCIATION OF AMERICA

Good Morning Mr. Chairman and Members of the Committee. My name is Dwight Cenac and I am the Chairman of the Board of Home Care Association of America (HCAA). HCAA represents over 300 freestanding, locally-owned and operated home health care agencies across the United States.

I am honored to have the opportunity to testify before you today about fraud and abuse in the Medicare system, about home health provisions found in the Balanced Budget Act of 1997; and about how they will affect the elderly homebound patients we serve.

I. HCAA's view on the reasons for the growth of home health waste, fraud and abuse

Let me begin by saying, that, in my opinion, there are several reasons that members of Congress have seen such an increase in home health waste, fraud and abuse.

1) HCFA is preventing competition in the home health industry. I recently read a quote from Chairman Bliley whereby he stated, "Last Congress, we broke up one of the biggest monopolies still standing, giving consumers a choice in local telephone service. It's time we did the same thing with electricity." He also said, "no economist can quarrel with" the notion that "competition lowers prices, competition improves productivity, and monopolies are always inefficient and expensive—always. That's not opinion, it's fact. You know it, I know it,... and history proves it."

Mr. Chairman, HCFA has prevented competition by not enforcing 42 CFR 424.22. This long-standing regulation prohibits doctors from referring patients to the hospital-owned home health agency if that doctor is compensated over $25,000 by the hospital. This lack of enforcement by HCFA, has in effect, raised home care costs significantly.

Secondly, HCFA has allowed hospital agencies to double-dip the Medicare system. The specifics of the double-dip can be found in my written testimony. However, I can say that one of the main thrusts of the current Columbia/HCA hospital investigation involves Columbia/HCA charging Medicare twice for the same service pertaining to home health care. This is no small issue. It is costing the Medicare program billions of dollars annually; and Columbia/HCA is just the tip of the iceberg of hospitals which are unethically overcharging Medicare's home health care benefit. I have brought several charts to show this point (copies of these charts can be found in my written testimony).

HCAA recommends that Congress require the President to be even-handed in his moratorium by immediately issuing a moratorium on hospital-chain Columbia/HCA from selling off its home care operations. This will at least send a signal to others. HCFA has already allowed home care felons Jeanette Garrison (HealthMaster in Georgia) and Jack Mills (ABC Home Health, also in Georgia) to sell the home health agencies they fraudulently built with Medicare funds, (after they were found guilty of fraud) for millions of dollars.

Thus, allowing them to profit, again, from Medicare fraud. Americans are outraged that this kind of abuse is going unchecked. If Columbia/HCA is required to pay any out-of-court settlement or is found guilty of violations of the law pertaining to its home health operations, HCAA recommends that Congress demand that HCFA decertify all Columbia/HCA's home care provider numbers, just as it (falsely) has done in the case of CSM Home Health Services, Inc. of Los Angeles, California.

In addition, we honestly believe that the HCFA (under Operation Restore Trust and the "Wedge Survey") is specifically targeting freestanding home health agencies. Just as the I.R.S. has seemed to have targeted small businessmen and women across the country, Operation Restore Trust and the Wedge Survey target freestanding home health care agency owners because they lack the resources to fight against HCFA.

Mr. Chairman, one of those small businessmen who has been falsely run out of business by HCFA under Operation Restore Trust is Marianno Valez of CSM Home Health Services, Inc. of Los Angeles, California. With your permission, I would like him to stand for a moment so that you can see that he is in attendance here today.

HCAA recommends that Congress demand that HCFA be even-handed in its ORT activities by expanding their audits to hospitals and large chains. HCAA calls upon Congress to instruct HCFA stop its "Double-Standard" targeting freestanding agencies while allowing hospitals and large chains to overcharge Medicare billions annually, as our previous charts have shown.

II. HCAAs views on the challenges HCFA will face in implementing the anti-fraud provisions in the Balanced Budget Act of 1997

Section 4312, entitled "Disclosure of Information and Surety Bonds," is very vague; and HCFA has been slow to provide guidance to home health agencies on this provision. HCFA must provide a "Bond Form" to home health agencies immediately so that agencies can comply with the January 1, 1998 deadline. Insurance agents from across the country have told us that they are unable to offer home health agency owners a surety bond without a bond form. In addition, the bond form must clarify that HCFA can access the bond only for an agency that has filed for bankruptcy or has been indicted for fraud. Without this clarification, HCFA could access the bond for any reason, and the cost of the surety bond would be too costly for most home health agency owners to afford.

HCAA recommends that Congress request that HCFA's final regulations state that such bonds cover no more than the current audit adjustment factor currently being used (falsely) to withhold funds from agencies; and that such audit adjustment factors be eliminated (in lieu of the requirement for agencies to post a bond.)

HCAA also recommends that providers which have been in existence for 3 years and which have successfully passed surveys and audits be exempted from such bonds. Congress should pass this recommendation into law via a technical amendment.

HCAA also recommends that HCFA be creative and allow Home Care Associations (such as HCAA) to set up a trust fund that would serve as the bond. For example, an association which establishes a trust fund for its smaller agency providers (with a minimum membership in the trust fund, for example, of 100 providers) could require that the fund be set at $20,000 in cash per provider which wants to participate in the trust. Obviously, $2 million in cash for 100 small agencies should be more than adequate. Secondly, large agencies (those doing over 50,000 visits per year) who have been in existence for over 3 years should be exempt.

III. HCAA's views on HCFA's other administrative proposals to address home health waste, fraud and abuse, including the home health moratorium

1) HCAA recommends that Congress instruct HCFA to vigorously enforce section 4321, entitled, "Nondiscrimination in Post-Hospital referral to home health agencies and other entities." This provision must be honored by hospitals, as they seem to self-refer to their hospital-owned/based home health agencies and to deny freedom of choice to Medicare patients.

2) HCAA recommends that Congress pass legislation to implement a Provider's Bill of Rights (which HCAA would help develop) which would shift the burden of proof from the home health agency owner to HCFA to require that HCFA prove the agency willingly committed fraud. This legislation would mirror HR 2676 that Chairman Archer introduced pertaining to the Internal Revenue Service and its abuses of power.

3) HCAA recommends that Congress investigate the legality and propriety of President Clinton's issuing a moratorium on new home health agencies. Alternatively, HCAA believes that each state should conduct criminal background checks before certifying home health agencies.

IV. HCAA's proposal to curb waste, fraud and abuse

HCAA recommends that Congress: 1) Instruct HCFA to vigorously enforce 42 CFR 424.22, which prohibits hospitals from self-referring to their hospital-owned agency if the hospital pays that doctor over $25,000 per year.

2) Instruct HCFA to honor the ruling of the Administrative Law Judges in the case of CSM Home Health Care, Inc. of Los Angeles, Ca. HCFA had improperly overturned judges' rulings. Also, HCFA and its designated intermediary have continued to harass this honorable agency (that has been found innocent of HCFA's charges that it violated Medicare Conditions of Participation.)

3) Instruct HCFA to stop targeting under Operation Restore Trust and The Wedge Surveys only freestanding home health agencies (who do not have the financial resources to fight a legal battle against HCFA); and to expand its audits to hospitals and large chains in the same intensity (i.e. level of hours expended).

4) Instruct HCFA to incorporate HCAA into a regularly-scheduled task force designed to root out and stop the sophisticated health care thief. Because of the high sensitivity of this request, we ask that HCFA meet privately (and have a separate task force) with any associations which wish to follow HCAA's recommendation.

5) Instruct HCFA to expand investigation of: (1), all agencies which, in the last six years, have entered into management contracts; and (2), all agencies which have subcontracted nurses from hospitals/assisted living facilities, or institutions owned by hospitals or assisted living facilities.

6) Hold hearings into the abuses of Medicare Intermediaries and of HCFA under (Operation Restore Trust and the Wedge Survey). Many honorable home health agencies throughout the country have been driven out of business by heavy-handed and over-zealous auditors and surveyors. Recent hearings into the Internal Revenue Service proved that IRS employees were over-zealous in recouping funds. The exact same scenario can be found under numerous instances of Intermediaries and HCFA's ORT and the Wedge Surveys. HCAA can provide home care owners to testify on the abuses they have encountered at the hands of government auditors; and on how these abuses of such efficient providers cause them to cost Medicare more per visit (even though their cost is still significantly less than hospitals).

7) Educate beneficiaries about eligibility requirements.

It is imperative to remember that the majority of home health patients are elderly and frail. Because of age and of other factors, their mental faculty is not comparable to that of younger Medicare beneficiaries. The majority of Medicare HMO patients (that are portrayed in full color newspaper ads or on television as healthy and physically-active) are not the same patients that receive home health services.

Currently, HCFA is disallowing any costs of activities of a freestanding agency to educate the community (i.e., Health Fairs, small radio and t.v. spots, etc.), even though HCFA's own manual (HCFA Pub. 15-1, Section 2136.1) states, "Allowable Advertising Costs.—Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care." While HCFA is denying freestanding agencies' reasonable advertising cost (permissible under Medicare policy), HCFA pays fees to Hospitals and HMOs allowing them to do false and misleading advertisement (i.e. full-page newspaper ads, billboard ads and television ads showing seniors riding bicycles or jogging—inviting them to attend an "educational seminar" at a local restaurant).

HCAA Recommendation: HCAA recommends that Congress both: a) Hold hearings on public awareness advertising disallowances being experienced by freestanding

agencies and b) Change the law (via a technical amendment) to require that HMOs and PSOs not just "offer" a similar benefit as in fee-for-service, but "provide" the benefit they offer. Failure to provide benefits should result in decertification. c) Demand that HCFA allow reasonable freestanding public awareness advertising in an effort to foster competition, drive down cost and protect patient choice.

Mr. Chairman, this concludes my verbal testimony. Again, let me say that I deeply appreciate the opportunity to testify today, and I look forward to working with you and others in stopping the runaway fraud in the Medicare system. I would be happy to answer any questions that you and the Committee may have.

Mr. BARTON. Thank you, Mr. Cenac.

We would now like to hear from Mr. Pyles; again, your statement is included in its entirety in the record, and we'd ask you to summarize in 7 minutes or less.

TESTIMONY OF JAMES C. PYLES

Mr. PYLES. Thank you, Mr. Chairman.

I'm James C. Pyles, appearing today on behalf of the Home Health Services and Staffing Association, and I truly want to commend this subcommittee for conducting this hearing and oversight. This is an area that desperately needs Congressional oversight. And, I hope this will only be the first of a series of hearings on this issue.

Home health offers the last best chance to provide Medicare services in an affordable form—fashion—to the growing number of Medicare beneficiaries who are going to need them in coming years. This was the conclusion by the Hudson Institute in a recent report based upon an analysis of Indiana's In-Home CHOICE program. The study found that the administration's moratorium and plan to turn loose regiments of auditors and draft tough new regulations on home health care, while well intended, is the wrong cure. The study concluded, based on the experience of the State of Indiana, that a well-conceived, publicly funded home health care program can outperform publicly funded institutionalization for the coming wave of baby boomer retirees.

Home health is the one service that preserves the independence of patients and avoids many Americans' worst nightmare: confinement in a nursing home. Surveys have shown that generally, the quality of home health care provided to Medicare patients is high, as is patient satisfaction.

So the public policy challenge should be: how can we preserve access to humane, cost-effective home care as a method of providing needed health care services to a rapidly growing Medicare population. Nowhere has this, or any other, overarching objective for home health been announced in the administration of the home health benefit.

We are, as an association, willing to assume our share of responsibility for ensuring that home health remains a cost-effective benefit. But we must also request that government officials act in accordance with the law and provide accurate information on which sound public policy decisions can be based.

Accordingly, we are announcing today, an initiative entitled, "Operation Responsibility and Accountability" under which we will periodically provide to this subcommittee, and to others in Congress, a summary of actions we have taken or supported to eliminate waste, fraud, and abuse, and to preserve home health as a cost-ef-

fective service for Medicare patients. We will also report to Congress cases of unlawful and abusive actions by government officials and inaccurate or misleading information.

We have proposed or supported the following actions designed to reduce waste, fraud, and abuse in the home health benefit:

First is prospective payment. The Home Health Services and Staffing Association, and the PPS work group, and others in the industry have worked intensively with Congress since 1994 to develop a fully formed prospective payment system to replace the antiquated and wasteful cost reimbursement system under Medicare. As illustrated by the experience with reimbursement for hospital in-patient services, home health services will not become truly cost effective until the cost reimbursement is replaced by prospective payment. Thus, the home health industry has developed and presented the only reform measure that is likely to have long-term effect.

We have also supported and worked with Congress and the administration on bonding requirements, the patient choice requirements, criminal background checks, coordination of fraud and abuse measures, and education of our members on how to make sure they comply with the fraud and abuse laws.

Now to the accountability arm of our initiative. We strongly support lawful efforts to eliminate unqualified home health providers and claims for non-covered services from Medicare, but we are deeply disturbed by the recent pattern of conduct by the administration which principally penalizes law-abiding providers and beneficiaries.

On September 15, the President announced in a speech that the administration was imposing an unprecedented moratorium on home health providers. The moratorium went into effect without warning, without issuance of a regulation, executive order, or other rule to the public, and without citing any legal basis. Hundreds of home health agencies across the country were stranded in the process of being certified, wasting hundreds of thousands of dollars and disrupting the services to hundreds of patients.

We believe the moratorium is an example of an ill-considered and wasteful public policy. It fails to distinguish between good and bad agencies, it principally penalizes the innocent—I would just note that when the FBI did their sting operation under this moratorium, they could not open a home health agency—and it appears to be in violation of Medicare law and the Constitution. And, this question will be addressed in a lawsuit which has been filed against the government in Jacksonville, Florida in Federal district court. We also see now, that based on—the moratorium was supposedly based on a recommendation from OIG, and that now does not appear to be accurate.

The second point I wanted to bring up is: on September 5, 1997, just 10 days before the President announced the moratorium, an United States court of appeals issued a decision finding that Federal agents had engaged in concerted pattern of making false statements and misleading allegations against a home health agency in North Carolina. The findings of that court of appeals are truly shocking. It found: first, that Federal agents had falsely stated that the agency had tabbed medical records in an effort to make

changes that would meet Medicare billing requirements; falsely stated that care givers were asked to alter medical records in a manner that would be difficult to detect; falsely stated that employees took medical records home for the purposes of altering them; falsely stated that the agency had billed for services not rendered; falsely stated that the agency had billed for services that were provided to a patient after his death; misstated the requirements under Medicare law with respect to when plans of treatment were required to be signed by a physician; falsely implied that the agency had previously engaged in fraudulent billing; and intentionally misled the court into believing that assertions by a witness related to recent conduct when, in fact, the alleged activity was so old as to be irrelevant.

Any home health agency in this country would be prosecuted criminally for any one of those actions. Also we find a case—the CSM case mentioned by Mr. Cenac, out of California—where a home health agency was wrongfully terminated from the Medicare program on the grounds that it was out of compliance with four conditions of participation; none of that was true, and was determined on appeal.

Also, we find in that case, a pattern of discrimination and abuse. A sworn statement in that case by a nurse and an attorney states that a State agency surveyor described the Federal surveys in that case as racially motivated and he didn't like what was going on. The sworn statement further quotes a statement by Federal surveyors that all bad home health agencies are run by Filipinos, and that another home health agency, all they did was treat drunks.

What I'm asking here: if this is clear pattern of abuse based on judicial findings, and we would just like to know what is the administration doing to prevent this pattern from continuing.

Thank you.

[The prepared statement of James C. Pyles follows:]

PREPARED STATEMENT OF JAMES C. PYLES ON BEHALF OF THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION

Mr. Chairman and members of the Subcommittee, I am James C. Pyles, appearing today on behalf of the Home Health Services and Staffing Association (HHSSA) which is one of the oldest, if not the oldest, national home health associations and which includes some of the largest providers of home health services as well as numerous small businesses. I want to commend this Subcommittee for looking into the administration of the Medicare home health benefit. Such oversight is just as badly needed as the recent oversight of the Internal Revenue Service.

Over the past few months, we have seen a relentless bashing of the home health community with allegations of "fly-by-night" providers, 40% of the services being fraudulent, and astronomical growth rates in spending. These allegations have led to reactionary measures such as the Administration's moratorium on new home provider numbers, and plans for increased claims review and cost report audits.

Nowhere in this "open season" on home health has there been any consideration of the role home health is to play in the future health delivery system and whether these measures further or detract from those objectives. A study just released by the Hudson Institute entitled *"The Cost Effectiveness of Home Health Care"* concludes that home health services probably represent the last best chance we have to provide the Medicare package of services to the rapidly increasing numbers of Medicare eligible patients. (Exhibit 1) Based upon an analysis of Indiana's In-Home/CHOICE program, the study found that the Administration's moratorium and plan to "turn loose regiments of auditors and draft 'tough new regulations' on HHC [home health care]" while well-intended, is the "wrong cure". The study concluded, based on the experience of the State of Indiana, that "... a well-conceived, publicly funded HHC [home health care] program can outperform publicly funded institu-

tionalization for the coming wave of Baby Boomer retirees". Report at 12. An example of a well-conceived home health care program, according to the study, is one that concentrates its administrative resources on "critical control points" such as eligibility of the patients and patient satisfaction. Report at 8.

Buried amidst the recent criticism of home health care are other characteristics of the services which are supported by anecdotal but widespread experience. Home health care is probably the most popular service covered by Medicare. It is the one service that preserves the independence of patients and avoids many Americans' worst nightmare—confinement in a nursing home. Surveys have shown that generally the quality of home care provided to Medicare patients is high, as is patient satisfaction.

So the challenge for policy makers should not be how can we curtail access to, and payments for, home health care. Rather the challenge should be how can we preserve access to humane and cost-effective home health care as a method of providing needed health care services to a rapidly growing Medicare patient population. Nowhere has this, or any other, overarching objective for home care been announced in the administration of the home health benefit.

"OPERATION RESPONSIBILITY AND ACCOUNTABILITY"

We are willing to assume our share of responsibility for ensuring that home health remains a cost-effective benefit. But we also request that government officials act in accordance with the law and provide accurate information on which sound policy decisions can be based.

Accordingly, we are announcing an initiative entitled "Operation Responsibility and Accountability" under which we will periodically provide to this Subcommittee and others in Congress (beginning with this testimony) a summary of actions we have taken or supported to eliminate waste, fraud and abuse and to preserve home health as a cost-effective service for Medicare patients. We will also report to Congress cases of unlawful and abusive actions by government officials and inaccurate or misleading information.

Responsibility

We have proposed or supported the following actions designed to reduce waste, fraud and abuse in the home health benefit.

1. Prospective payment—HHSSA, the PPS Work Group and others in the industry have worked intensively with Congress since 1994 to develop a fully formed prospective payment system to replace the antiquated and wasteful cost reimbursement system under Medicare. The home health industry's PPS plan passed Congress as part of the Balanced Budget Act of 1995, but was not implemented when the bill was vetoed. Had the bill not been vetoed, we would be in the second year of achieving savings from home health under a prospective payment system. Implementation of a prospective payment system was the number one recommendation coming out of the Office of the Inspector General's Operation Restore Trust. See *Results of the Operation Restore Trust Audit of the Medicare Home Health Service,* p. 3, OIG (July 1997).

As illustrated by the experience with reimbursement for hospital inpatient services, home health services will not become truly cost effective until the cost reimbursement system is replaced by prospective payment. Thus, the home health industry has developed and presented the *only* reform measure which is likely to be effective.

The industry's PPS plan was rejected in the Balanced Budget Act of 1997 in favor of the Administration's plan to retain the antiquated and wasteful cost reimbursement system for another two years and to then allow the Secretary to develop and implement a completely unspecified PPS plan.

Thus, the home health industry accomplished a task which had never before been achieved in the history of the Medicare program. Virtually the entire industry, including all types of providers, came together in unified support of a comprehensive plan to reform its reimbursement system and achieve true savings only from its own services.

We have also offered our knowledge and support to HCFA to assist them in developing a prospective payment system by the October 1, 1999 deadline established in BBA '97. The interim modification to the cost reimbursement system creates even more perverse incentives than did the original system. Accordingly, we urge this Subcommittee to obtain from the Administration a schedule of steps they are taking to implement PPS by October 1999 and insist on periodic reports to ensure that this schedule is met.

2. Bonding—We worked with members of Congress on the surety bond requirement which was included in BBA '97. See sec. 4312(b). We have also offered our experience and assistance to HCFA in drafting regulations implementing this requirement by the January 1998 effective date.

3. Patient choice—We worked with members of Congress on the requirements in BBA '97 that patients be given a choice of home health providers. See sec. 4321.

4. Criminal background checks—We have worked with the Administration, members of Congress and many States to develop an effective, low cost method of performing criminal background checks on home health care givers.

5. Coordination on fraud and abuse measures—We have worked with members of Congress and the Office of the Inspector General to suggest measures which might be effective in detecting waste, fraud and abuse in home care.

6. Education—We have also encouraged all home health providers to develop and implement both corporate and regulatory compliance plans to help ensure that all legal requirements are met.

Accountability

While we strongly support lawful efforts to eliminate unqualified home health providers and claims for non-covered services from Medicare, we are deeply disturbed by a recent pattern of conduct by the Administration which principally penalizes law-abiding providers and beneficiaries.

1. The moratorium—On September 15, the President announced in a speech that the Administration was imposing an "unprecedented" moratorium on new home health provider numbers. The moratorium went into effect immediately, without warning, without the issuance of a regulation, executive order, or other rule to the public, and without any citing any legal basis. Hundreds of home health agencies and their patients across the country were stranded in the process of being certified. See letters from agencies in Pennsylvania and Texas and letters from Senators Specter of Pennsylvania and Bond of Missouri (Exhibit 2). These agencies are now in jeopardy of losing hundreds of thousands of dollars invested in space and personnel costs. Smaller companies are in jeopardy of having to default on small business loans. See letter from Senator Bond. Agencies are having to lay off workers and discharge patients they were required to treat in order to prove that they were worthy of certification.

The moratorium does not even appear to accomplish the purpose for which it was announced. The purpose ostensibly was "to ensure that no fly-by-night providers enter into or remain in the Medicare program". The moratorium, however, makes no distinction between "fly-by-night" providers and reputable providers that meet all lawfully established requirements. In fact, the moratorium prevents the most qualified provider in the country from participating in Medicare while "fly-by-night" providers which the Administration alleges are already in the program are protected from competition.

The apparent reason that the moratorium fails to distinguish between law-abiding and "fly-by-night" providers is the false assumption that fraud and abuse is the "prevalent" condition in the home health industry. See Press Release from the Department of Health and Human Services (Sept. 15, 1997) There is no evidence to support this assumption.

Further, the moratorium appears to punish innocent providers in an attempt to address an issue which the Administration has created. The President stated that the Administration was motivated to impose the moratorium by the fact that "[e]very month, nearly 100 new home health providers—new ones—enter the Medicare program". The increase in new home health providers over past several years has been caused, at least in part, by the Administration's "branch office conversion" policy under which hundreds of branch offices, which are not required to have a separate provider number, have been required to convert to new provider status.

In any event, the Administration has insisted for years that only it can make the initial certification and periodic recertification determinations concerning whether a home health provider meets the hundreds of statutory, regulatory and manual requirements for participation in the Medicare program. See sections 1891 of the Act, 42 C.F.R. 484.1, and Medicare State Operations Manual, App. B. Thus, if "fly-by-night" home health providers are participating in the Medicare program, it is because they have been expressly approved by the Administration.

Finally, the moratorium appears to be in conflict with the Medicare Act and usurps power that rests exclusively with Congress. The Act provides that *"[a]ny provider of services* . . . shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement . . ." to meet the requirements set forth or authorized by statute. Section 1866(a)(1) of the Act (emphasis supplied). Under the moratorium, however, *no provider of home*

health services is permitted to participate in Medicare or to be entitled to Medicare payments even if it files an agreement with the Secretary and meets all lawfully issued requirements.

The Act further states that "[t]he Secretary may refuse to enter into an agreement under this section, or upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary..." has determined that the provider fails to meet or has violated requirements established under the Act. Section 1866(b)(2). Under the moratorium, however, the Secretary is refusing to enter into provider agreements with providers without making *any* determination with respect to the providers' qualifications.

Congress passed sweeping revisions to the Medicare Act in the Balanced Budget Act of 1997 giving the Secretary broad powers to revise coverage, reimbursement and provider participation rules for home health services. Congress even gave the Secretary added authority to refuse to enter into an agreement with a home health provider that has been convicted of a felony under Federal or State law. See sec. 4302 of BBA '97. *Congress did not, however, give the Secretary the authority to refuse to enter into a provider agreement with a home health provider regardless of its qualifications.*

Finally, the moratorium appears to violate the requirements in section 1866(h) of the Act that the Secretary provide a determination on a provider application which can then be appealed to an administrative law judge and to federal court. The moratorium bars the exercise of those due process rights and in so doing, not only violates the Medicare Act but also the Fifth Amendment to the U.S. Constitution.

The Administration has never provided the public with a legal basis for its action and initially failed to provide any basis even to Congress. We understand that the Administration has belatedly tried to justify its actions by relying on sections 1861(o)(7) and 1891(b) of the Act. Those sections, however, simply authorize the Secretary to establish certain conditions and requirements which home health agencies must meet in order to participate in Medicare. Under the moratorium, "HCFA will not enter into new HHA provider agreements" *regardless* of whether the HHA meets the conditions of participation and other lawfully established requirements. In short, there is no authority in the Act which confers power on the Secretary to refuse to enter into provider agreements with qualified providers, and we believe legal staff for the subcommittee will concur in this conclusion.

It is true, as the Administration has contended that a moratorium was recommended by the Office of the Inspector General. OIG withdrew that recommendation, however, when it agreed with HCFA's response that

> "HCFA has the responsibility to establish and implement adequate program requirements and safeguards. If an HHA is able to comply with these requirements, it should be allowed to enter the Medicare program."

See *Home Health: Problem Providers and Their Impact on Medicare,* p. 19 and Appendix D, p. 4 (letter from Bruce Vladeck to June Gibbs Brown, July 21, 1997).

The legality of the moratorium may well be addressed in the legal action filed against the Administration on October 23, in U.S. District Court for the Middle District of Florida. See *Putnam Home Health Care, Inc. v. Shalala.* Regardless of the decision of the court, the moratorium punishes innocent providers for the Administration's past failure to distinguish between good and bad providers.

2. False Statements by Agents of the Administration—On September 5, 1997, just 10 days before the President announced the moratorium, a United States Court of Appeals in Richmond, Virginia issued a decision upholding a lower court's findings that federal agents (including an IRS agent) had engaged in a concerted pattern of making false statements and misleading statements in falsely accusing a home health agency in North Carolina of fraud. See, *U.S. v. Home Health and Hospice, Inc.* (4th Cir. Sept. 5, 1997). Specifically, the Court found that the federal agents had

1. falsely stated that a witness had indicated that the HHA had tabbed medical records in an effort to make changes that would meet Medicare billing requirements;
2. falsely stated that a witness had indicated that caregivers were asked to alter medical records in a manner that would be difficult to detect;
3. falsely stated that a witness had indicated that employees took medical records home for the purposes of altering them;
4. falsely stated that the HHA had billed for services not rendered;
5. falsely stated that the HHA had billed for services that were provided to a patient after his death;
6. misstated the requirements under Medicare law with respect to when plans of treatment were required to be signed by a physician;

7. falsely implied that the HHA had previously engaged in fraudulent billing of Medicare; and

8. intentionally misled the court into believing that assertions by a witness related to recent conduct when, in fact, the alleged activity was so old as to be irrelevant.

3. HHA Improperly Terminated from Medicare

On July 23, 1997, less than two months before the Administration's moratorium, a decision was issued by an HHS Departmental Appeals Board panel holding that a home health agency in California had been wrongfully terminated from the Medicare program. See *CSM Home Health Services, Inc. v. Health Care Financing Administration,* Dec. No. 1622 (July 23, 1997). Unfortunately, this decision came after the wrongful termination, so the agency has been financially destroyed.

In that case, the Administration accused the home health provider (which was a small business) of being out of compliance with four conditions of participation—(a) organization, services and administration, (b) acceptance of patients, plan of care, and medical supervision, (c) skilled nursing services, and (d) evaluation of the agency's program. After an evidentiary hearing, an administrative law judge found that the Administration's factual and legal allegations were erroneous with respect to each of the conditions. The Administration took an appeal and, after full briefing by both parties, the Departmental Appeals Board Appellate Division unanimously confirmed the ALJ's conclusions that the home health agency had been wrongly accused.

The home health provider in that case sought and obtained a preliminary injunction in Federal District Court, and the federal judge made the following findings in granting the injunction:

> There's evidence that all of the conditions of participation have not only been met but maybe they've been exceeded. There's evidence that there's a number of errors in the statements of deficiencies. There's evidence that the survey findings issued by the Health Care Financing Administration were not in compliance with the Medicare conditions of participation and that... the original survey and the resurvey findings were, in fact, based on erroneous interpretations of Federal regulations and guidelines and were inconsistent with long-standing interpretations of the Health Care Financing Administration. That's the way the evidence looks to me.
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> * * * * *
>
> *The surveyors, I had the impression, were not reticent to wear their power on their cuff (sic) and to manifest it and exercise it in ways that are undesirable in today's society. The bureaucracy has overreacted again. That is my view of this case.* (Emphasis supplied.)

CSM Home Health Services, Inc. v. Shalala, No. CV 96-4651-JGD, Transcript of Preliminary Injunction hearing pp. 35-6 (July 19, 1996). This preliminary injunction ultimately expired when the court concluded reluctantly that it had no jurisdiction to afford relief to the provider.

Thus, a Federal District Court Judge, an administrative law judge, and a three-member panel of the Departmental Appeals Board for the Department of Health and Human services all reached the same conclusion that the Medicare agreement for a home health provider had been improperly terminated based on erroneous allegations of law and fact by agents of the Administration.

4. Federal Agents Engage in Pattern of Discrimination and Abuse

During the course of the *CSM* case, facts emerged which depict a disturbing pattern of abuse of federal power by Administration employees. In a sworn statement filed with the court on behalf of CSM by an individual who is both a nurse and an attorney, a State Agency surveyor is described as stating that he believed the federal surveys and termination actions against home health agencies in California were "racially motivated" and that he "didn't like what was going on". Declaration of Gina M. Reese, para. 26 (July 19, 1996). This State Agency employee tried to put minority-owned home health agencies in contact with competent counsel so that they could defend themselves against the improper actions of federal agents.

The sworn statement further quotes a statement made by federal surveyors that "all the bad [home health] agencies are run by Filipinos". Reese declaration, para. 25. A federal surveyor also stated to a home health agency's patients that they should not use that agency because all they treat are "drunks". Reese declaration, para. 27.

The sworn statement also refers to a "Medicare Compliance Alert" which states that a home health agency was terminated from the Medicare program "... based on the allegation that a single diabetic patient's doctor was not notified about elevated blood sugar levels" and that the "agency had documentation of the notifica-

tion, but was not given a sufficient chance to produce it." Reese declaration, para. 31. Further, the Associate Regional Administrator for the Department of Health and Human Services for the California Region is reported to have agreed that federal surveyors had erroneously cited home health agencies for deficiencies. Reese declaration, para. 30.

The foregoing describes a clear pattern of abuse of law-abiding individuals and small (and large) businesses at the hands of the branch of the federal government charged with preventing abuse. The unlawful action and abuse described above is either clear on its face, the subject of findings after an adversarial proceeding or is based on sworn statements.

Nearly every type of abuse which was revealed in the recent review of the Internal Revenue Service is reflected in the findings of the above cases. We hope that the Subcommittee will work with us to prevent this type of abuse from becoming more widespread.

5. Incomplete or misleading data

A variety of reports and data were presented to Congress near the end of the intensive and compressed process that culminated in BBA '97. There was little time to evaluate those reports and data. We urge Congress to consider that data carefully, especially where it conflicts with past experience because bad data leads to bad public policy.

For example, a report was presented that alleged that 40% of all home health services that were covered by Medicare in 1996 should not have been covered. See *Results of the Operation Restore Trust Audit of Medicare Home Health Services,* OIG, p. 1 (July 1997). This report has been erroneously cited for the proposition that 40% of home health claims are fraudulent even though the report itself does not make this assertion.

In any event, it must be kept in mind that the conclusion in the report is based on a review of only 250 claims out of more than 20 million filed during the period covered by the review.

Even more importantly, it appears that the conclusions in the report are based on *recommended* actions with respect to claims that already have received "final and binding" favorable coverage determinations under the Medicare claims adjudication process. Thus, it is impossible to know how many of those claims ultimately would be found non-covered if the initial determinations were reopened and reversed.

We know, however, based on a prior GAO report, that of the 16.6 million Medicare home health claims filed in 1994, only 3.7% were denied. See *Medicare Home Health Utilization Expands While Program Controls Deteriorate* GAO (March 27, 1996). We know further that of the 3.7% that were denied, only .6% were denied because the services were determined, after medical review to not be medically necessary or because the beneficiary did not meet the coverage criteria.

We also know that when home health claim denials are appealed to an independent trier of fact, such as an administrative law judge, approximately 88% of the appeals are decided in favor of the provider. It could be argued that there is some "self selection" in this figure because providers presumably will only appeal cases which they believe are strong. Self selection by the provider, however, may be counter balanced by self selection by the intermediary. Presumably the intermediary will simply pay claims where it believes it cannot prevail on appeal. It is often pointed out that the providers do not appeal many denials. However, it is likely that many claim denials are not appealed because they do not meet the $100 jurisdictional amount requirement for a hearing, or if they do, the amount in controversy is still too small to justify the expense of the appeal.

The salient point which has been lost in the recent reports is that when both the intermediary and the provider have had an opportunity to select which denied claims should be presented to an independent trier of fact and both have had an opportunity to fully develop the record, nearly 9 out of 10 cases are decided in favor of coverage. At the very least, the conclusion that 40% of home health claims should not have been covered should be considered in the context of this experience.

It has also been stated repeatedly that the rate of growth in home health expenditures is "out of control" and is higher than the growth rate for any other service covered under Medicare. The facts do not support this conclusion. The attached chart based on Congressional Budget Office baseline projections shows that the rate of growth in Medicare home health expenditures has declined precipitously since 1990, will drop to 9.8% in 1999 and remain below 10% through the year 2007, *even if none of the provisions of BBA '97 are implemented.* (Exhibit 3) CBO projections further show that the rate of expenditure growth for skilled nursing facility services will exceed the rate of growth in expenditures for home health services in both 1996 and 1997. Finally, CBO projections show that the rate of growth in home health ex-

penditures is comparable to the rate of growth in total Medicare outlays for the period 1998 through 2007, again not taking into account the changes in BBA '97.

Accordingly, we urge Congress to collect complete data and obtain input from the home health community to ensure that sound public policy is made with respect to home health.

Recommendations

Based on the foregoing information, we offer the following recommendations:

1. Establish a broad public policy objective which defines the desired role for home health services to play in the future health delivery system. (We suggest, based in part on the findings of the Hudson Institute report, that this objective be to preserve home health as a cost-effective method of providing services to the rapidly increasing Medicare patient population.)

2. Require laws and regulations to be evaluated to determine whether they further or detract from this objective. In this connection, careful consideration should be given to ways to avoid and reduce administrative costs both for the government and for providers since those costs will eventually divert funds from services.

3. Conduct a review to determine what actions have been taken to hold the federal agents in the *Home Health and Hospice* and *CSM* cases accountable for their actions and to prevent such abuse from recurring.

4. Request the Administration to explain why it has been unable to distinguish between reputable and "fly-by-night" home health providers under existing laws and standards which include more than 80 statutory provisions, nearly 180 regulatory provisions, approximately 100 manual provisions, and state and local laws and professional standards which are incorporated by reference into the conditions of participation for home health agencies. (This question is particularly pertinent in view of the fact that many of these standards have been in place for nearly 25 years, and the Secretary has been given the authority to add virtually any new standard or requirement.)

5. Request the Administration to set forth for the public the precise legal basis for the moratorium and a date on which it will be lifted.

6. Request the Administration to provide a summary of the total number of providers affected by the moratorium and the estimated impact of the moratorium on these providers and the patients they are currently treating.

We look forward to working with this Subcommittee and the Health Care Financing Administration to ensure that home health services are regarded as part of the solution and not part of the problem of health care delivery.

Mr. BARTON. Thank you.

We would now like to hear from Ms. Raphael; and again, your statement is in the record, so we try asking you to summarize it in 7 minutes or less.

TESTIMONY OF CAROL RAPHAEL

Ms. RAPHAEL. Thank you, Mr. Chairman.

I want to commend the chairman and the committee for holding this oversight hearing, and for taking a look at the issues of not only untrustworthy providers but also the whole system of home health care.

I represent the largest not-for-profit home health care organization in the United States. I think when we were created, the 52nd session of Congress was being held. I would like to think I also represent agencies in Pennsylvania and Texas and Iowa, and Oklahoma, who are trying to really ensure that home health care remains the valuable part of the health care system it is, and available to people who overwhelmingly prefer it to remaining in hospitals or having to enter nursing homes.

We very much want to see some systemic reforms of the home health care program, and I'm going to focus on four areas that I think need attention.

First of all, I urge you to raise the standard for entry into the home health care program. The bar is too low. Every week we pro-

vide home health care in 22,000 different homes. The kind of infrastructure that you need to provide quality care in that kind of decentralized system is extraordinary and it requires, I think, a tremendous background in health care. I've worked in a hospital, and I would tell you that working in a hospital is far easier than trying to manage a home health care system. And, I really think that you have to focus on changing the requirements so that there are requirements involving character, competence, a proven track record, and financial viability going forward.

Second, I urge you to really involve consumers. I think that it is vital that they have good information about home health care providers. We're participating in a National demonstration to really look at outcomes and where we stand among the 50 agencies in this demonstration. Consumers ought to get that kind of information. The best disinfectant is really putting things out in the light. Second, I think that will really make real consumers freedom of choice, which I think we all want to see them have the chance to exercise.

Third, you have to strengthen the monitoring system. And, I think, that it isn't always an issue of adding resources, it's how you target those resources. You need to target them to those agencies who are new, those agencies who are problem agencies. We need to use technology in new ways. I know you discussed some of the problems with systems this morning, but the systems that we have can really target agencies that have patterns that don't really adhere to the norms. And I think you need to look at agencies like my agency, which really is trying to exceed the standards. And, you always have to think about standards; are they going to be the floor or the ceiling? And, how do you put in the incentives so that we always want to do better and create more value for you as the purchasers of home health care?

There are five things that we do that I think could really form the basis for some minimum standards. First of all, we have a corporate compliance program, and we spend a lot of time with our nearly 8,000 employees going through what is legal, ethical, proper behavior; what are the procedures; and how to report any infractions that they discover.

Second, we have our own quality management program. No matter how much you survey, you're not going to be in an agency every single day. And you have to trust the agencies and give them the incentives to do the right thing when you're not looking over their shoulder. And, I think any agency should be required to have a quality management program.

Third, we do criminal background checks. We're not required to do it, but we do it, for everyone who goes into the field. And you're dealing with a very frail, vulnerable population. Our average patient is a 79-year-old female who has not one diagnosis, but at least two diagnoses. And we have patients now, I just looked at our latest computer printout, we have 267 patients over the age of 95, and quite a few over the age of 100, which is always encouraging for me as I now look forward. And, I really think that we have to err on the side of doing everything we can to try to protect and prevent problems, not only zooming in once they in fact arise.

Fourth, we do a patient satisfaction survey. We have the Gallop organization do it. There are many others who can be used as well. And we try to look at systemic problems and get feedback on a regular basis.

And, last, we do internal audits. We make believe that we're HCFA, and we come in——

Mr. BARTON. God help you.

Ms. RAPHAEL. [continuing] we have quite a training program to train people to be HCFA-like.

We really train people to come in and really pull bills, pull documents, visit patients, and really see whether or not we're adhering to the vast number of regulations that should guide behavior in this area. And, we use that to really try to improve ourselves.

So, I think that you need to take a look at other very fine organizations and see what we can use and learn and adapt from what they're doing.

And, last, I think that for all of us, there needs to be some way of dealing with those providers who in fact engage in egregious practices. To keep our morale high, you need to have some kind of sanctions that are interim sanctions and that don't necessarily lead to ejection from the program but may involve freezing someone's caseload, or some other method of dealing with someone on an interim basis or in an incremental way.

So, I hope that my testimony has been helpful, and I look forward to answering any questions the committee may have.

Thank you very much.

[The prepared statement of Carol Raphael follows:]

PREPARED STATEMENT OF CAROL RAPHAEL, PRESIDENT & CEO, VISITING NURSE SERVICE OF NEW YORK

Good morning, my name is Carol Raphael. I am the President and CEO of the Visiting Nurse Service of New York. I appreciate the opportunity to be here with you today to discuss efforts to improve quality and maintain program integrity in the Medicare home health benefit. In particular, I want to discuss what I believe are the steps needed to ensure that the questionable practices of a few problem providers do not jeopardize the ability of efficient, high quality agencies to provide home health care to those who truly need it.

The Visiting Nurse Service of New York (VNSNY) is the nation's largest not-for-profit home health agency in the country. Based on over one hundred years of experience in serving the diverse populations of New York City, VNSNY has a real understanding of the needs of home care patients, and of the challenges of providing care to those who need it. My comments this morning will focus on: (1) the need for reforms to improve quality and maintain program integrity in the Medicare home health benefit; (2) recommendations for reform based on steps VNSNY has taken to ensure quality; and (3) how we anticipate that the changes recently enacted in the Balanced Budget Act of 1997 (BBA) will impact home health care providers.

THE NEED FOR REFORM

As you have heard, many factors have contributed to growth in the Medicare home health benefit resulting in increased utilization and costs. These include more medically complex, older patients with high service needs who are discharged from hospitals earlier than in the past.

Today, people over 65 represent almost 13 percent of the U.S. population and they are expected to account for 20 percent of the population by the year 2030; the fastest growing segments are those over 85. In addition, more people are living longer with chronic illness. Nurses see more people coming to them for help in their 80s and 90s who suffer from heart disease, diseases of the circulatory system, cancer, hypertension, diabetes, and the aftermath of a stroke. A typical patient seen by VNSNY nurses is a 79 year old female with congestive heart failure. In addition,

new advances in medical technology make it possible for agencies to treat patients at home who are discharged earlier from hospitals.

In the past decade, there has also been an increase in the number of home health agencies and a change in provider auspice. While the number of home health agencies that participate in the Medicare program has increased 60 percent (from nearly 6,000 in 1990 to more than 9,000 in 1995), the effect of this growth on utilization and costs is not known. In the future, we believe we will see more for-profit agencies competing for home care patients. While recent studies by the General Accounting Office and the Kaiser Family Foundation have indicated that for-profit agencies provide more visits per patient than non-profits, the extent to which this is related to inappropriate utilization is also unclear.

Although some of the studies by the General Accounting Office and Inspector General allege widespread fraud among home health agencies, in some cases they are based on small samples and the widespread generalization of their findings is questionable. However, given that there is some evidence of inappropriate practices in some states that should be rooted out, VNSNY supports additional efforts to prevent, detect, and eliminate fraud and abuse to improve performance and outcomes of care. Reform is needed to restore the confidence of Medicare beneficiaries that the home health services they receive are legitimate and are provided by trained and competent staff.

RECOMMENDATIONS FOR REFORM

Some actions have been taken at both the federal level and the state level to prevent fraud. New York State, for example, limited the number of home health agencies through a certificate of need process (as have about one half of all states) and has mandated that existing agencies have full reviews of character, competence, and financial viability. These actions have gone far toward keeping out unscrupulous providers, but clearly more needs to be done. The challenge for Congress and HCFA is to achieve needed reforms by implementing the BBA, building on federal and state efforts, and bench marking the successful practices of reputable providers.

VNSNY, along with many other reputable providers throughout the country, has undertaken numerous efforts over the course of years to maintain high standards of quality. These initiatives could serve as a strong foundation to build minimum practice standards for providers across the country.

In moving toward implementing existing provisions and enacting additional reforms, I believe there are four main areas to focus on: (1) raising standards for entry; (2) increasing information to consumers to make informed decisions; (3) strengthening oversight by the federal government and its agents; and (4) sanctioning unscrupulous providers.

Raising Standards for Entry

Home health care has changed significantly over the past decade. It should not be surprising that the rules that were created to govern home health agencies in the early 1980's may need to be revisited today.

In many states today, there are low entry requirements and little capital needed to open a home health agency. The complex, decentralized system requires that standards and credentials for entry to operate home health agencies must be high. Care provided to patients in their own homes differs dramatically from that provided in hospitals or nursing homes. Unlike hospital care that is provided in a single site, home care is provided in numerous sites—the VNSNY, for example, delivers care at 22,000 homes each week. A formidable challenge is to build the infrastructure and manage a decentralized system and ensure quality to a medically complex, highly dispersed patient population.

Specifically, home health care providers should be able to demonstrate basic competencies in order to get a license to practice. Owners of new and existing home health agencies should be required to meet strict standards on character and competence. Key individuals and agencies should demonstrate proficiency (e.g., prior health care experience, a proven track record for high standards and quality, continuing education, knowledge of reimbursement requirements) as documented by state or national accrediting bodies. Criminal background checks on agency employees should be conducted, using a national data base. VNSNY currently conducts criminal background checks and drug screening on all health workers who enter a patient's home.

Furthermore, prior to certification, new home health agencies should provide evidence that they are financially sound and responsible. This could be achieved by implementing the surety bond provision required by the BBA and requiring agencies to pay for the Medicare application fee and the cost of an initial survey.

VNSNY supports the continuation of President Clinton's home health agency moratorium to allow the Health Care Financing Administration (HCFA) to develop standards that ensure that only ethical, honest and qualified home care providers are certified to care for Medicare patients. The moratorium should be applied in all instances except for agencies that were already in the pipeline for Medicare approval and in cases where there is demonstrated unmet need.

States also have an important role to play in providing adequate reviews of new agencies and in assuring that the number of new agencies being approved is reasonable—in some states, there are over 100 new agencies being approved per month. New York State already has a moratorium on the creation of new certified home health agencies which is intended to halt the influx of agencies and prevent the proliferation of providers that is occurring in some states.

Increasing Information to Consumers to Make Informed Decisions

Home health care is often a viable and preferable alternative to hospital and nursing home stays. When managed properly, home health care can save the health care system money. In fact, home care can be substituted for more expensive care provided in hospitals and nursing homes. Recent studies published in the *New England Journal of Medicine* provide evidence for this. Rich and colleagues found that the rate of hospital readmission for people with heart failure declined by 44 percent as the result of a nurse-directed intervention, including intensive home care follow-up. [2/11/95, *New England Journal of Medicine*] Stuck and colleagues determined that with comprehensive home assessments, permanent admissions to nursing homes dropped from 10 to 4 percent. [2/11/95, *New England Journal of Medicine*].

We should not let a few providers who take advantage of the current system take away this choice for millions of Americans who rely on and prefer home care. Instead, the role of beneficiaries, nurses, home health agencies, fiscal intermediaries, and federal and state governments should all be strengthened to improve performance and outcomes.

For example, information that is provided to beneficiaries should be improved to enable them to make informed choices. VNSNY currently participates in a national demonstration effort to collect information on quality outcomes. From this kind of data, consumer report cards could be developed to help beneficiaries discriminate between providers. However, information means little if consumers cannot exercise free choice. It is essential that HCFA reinforce the right and ability of beneficiaries to choose the provider they want.

VNSNY regularly monitors quality by conducting patient satisfaction surveys. There are now about a half dozen national organizations that have developed satisfaction surveys which they market to the home health industry. These organizations include The Gallup Organization, the Picker Institute, and Press-Ganey Associates. The questionnaires they use are all similar, and most of the organizations offer some bench-marking capacity. In the future, every organization should be required to conduct routine surveys of their patients and to make system adjustments based on their results.

Strengthening Oversight by the Federal Government and its Agents

The decentralized nature of home health care and the challenge of monitoring the actions of a multi-disciplinary work force create the need to devise incentives to encourage all home health agencies to do the right things every day, especially in times when the government and accrediting bodies are not looking over their shoulder. More comprehensive and unannounced surveys should be conducted during the first few years of a home health agency's operation to look at compliance with regulations, staff credentials, billing practices and quality management systems.

Long before the General Accounting Office and the Inspector General issued reports about improving quality of care, VNSNY created a separate Internal Audit Department which undertakes operational and financial reviews, prepares reports to the Board, and recommends and monitors improvements based on findings. For example, the work of this department resulted in the creation of a new billing system that prevents bills from being sent to Medicare if they do not reflect a signed physician's order. Additionally, the Internal Audit Department spearheaded the development of a corporate compliance plan to ensure compliance with regulations and agency policies and providers, and to educate all staff on standards of legal and ethical behavior. I believe that the implementation of a Compliance Plan should be required as a Medicare Condition of Participation.

VNSNY also reviews quality and utilization of its services through an ambitious Quality Management Program. Currently, retrospective and focused reviews are conducted throughout the year to assess appropriateness of care and utilization of

services. In the future, all home health agencies should be required to implement a Quality Management Program.

The operations of fiscal intermediaries need to be transformed so that auditors and surveyors have expertise in home care, a better understanding of the Medicare program, and how it interacts with States' Medicaid programs. Also, fiscal intermediaries should have more of a presence in the States for which they process claims to assure better oversight and understanding of the needs of the community.

Sanctioning Unscrupulous Providers

Once fraudulent providers are identified, actions should be taken to make sure that they cannot continue to defraud the Medicare program or are unable to continue to obtain Medicare reimbursement, and that full restitution is made. It is essential that HCFA be allowed to impose interim sanctions, such as freezing Medicare case levels, for home health care agencies that fail to provide appropriate services and fraudulently bill the Medicare program.

In addition, HCFA should be able to eject fraudulent providers by fully enforcing the new provision in the BBA that excludes from Medicare providers with convictions for offenses under the program. In addition, the exclusion process should be expedited. Swift actions will send a strong message to the industry about the kinds of practices that will be supported by the Medicare program.

IMPACT OF CHANGES ON PROVIDERS

While you are already aware that costs for Medicare home health care have increased for many legitimate reasons, you should also be aware that the BBA has taken dramatic steps to decrease utilization and costs. In October, a new system of paying providers will be implemented which involves paying providers the lowest of (1) actual costs; (2) reduced cost limits; or (3) a new agency-specific per beneficiary cap. In many cases, this interim payment system will have the unintended effect of reducing payments to providers by as much as 30 percent and locking in current inequities in regional utilization.

The BBA also calls for a Prospective Payment System (PPS) for home health care that will hopefully provide incentives to manage costs within a reasonable price. HCFA will need adequate resources to implement this system. In particular, HCFA will need to (1) define episodes and outliers based on current demonstration programs by July 1998; (2) determine a case-mix adjuster by January 1999; and (3) determine a data base needed to set episode payment rates by June 1999. It might be helpful if HCFA had a clinical and technical advisory group to assist in this complex endeavor. VNSNY wants to do all we can to contribute to the development of a fair and effective PPS. A lot is at stake here. If HCFA is unable to meet its mandated deadline of October 1, 1999, the home health industry will be penalized for an inaction over which it has no control, and payments to home health agencies will be cut by an additional 15 percent.

Accordingly, I urge Congress to allocate adequate resources to HCFA to implement the most accurate and reliable PPS possible, and to require that HCFA regularly report back to Congress on its progress on milestones.

Thank you for giving me the opportunity to talk with you today. I look forward to answering any questions that you may have.

Mr. BARTON. Thank you, ma'am.

We would now like to hear from Ms. Mary Suther, and I'm told that you're a constituent of mine. I haven't met you before, but, if you're one of my bosses, I'm very delighted to see you here.

Ms. SUTHER. You've met my staff.

Mr. BARTON. Okay. So, your testimony is in the record in its entirety, and you're recognized for 7 minutes to summarize it.

TESTIMONY OF MARY SUTHER

Ms. SUTHER. Thank you very much for the opportunity to present testimony today.

My name is Mary Suther, and I am the president and chief executive officer of the Visiting Nurse Association of Texas. We are a very large not-for-profit organization—not as large as SUN-New York—but, we also serve 55 counties, both rural and urban counties. And, I'm also chairman of the board of the National Associa-

tion for Home Care, which is the largest National organization representing home care providers, hospice providers, and home health aid providers in the country. Not only do they represent that variety, but they also represent non-profit, for-profit, governmental agencies, free-standing, and community-based agencies.

The National Association for Home Care does not deny that there's fraud in the home care industry. For every dollar of home care fraud, there is a dollar less to be spent on delivering care to needy beneficiaries. For that reason, NAHC has a zero tolerance for fraud policy, and waste and abuse.

Before Congress considers further changes in the Medicare home care program, we urge that you assess the impact of the new provisions of the Balance Budge Act on the benefit. The BBA establishes a new reimbursement structure for home health and contains stringent requirements designed to curtail fraud that will force providers to drastically alter the way they do business and deliver care—and we don't disagree that some should. My written testimony analyzes the potential impact of these provisions and outlines anticipated changes in behavior by home health providers in adapting to the new regulations and cost structure—and Dr. Coburn was exactly correct in some of his statements today with respect to that.

The BBA establishes an interim payment system that will remain in effect until a new prospective payment is implemented in October 1999. CBO estimates that the new Medicare home care reimbursement system will achieve $16.2 billion in savings over the next 5 years; a 13 percent reduction in projected outlays for home care.

Our association estimates that 75 percent of the home care agencies currently in operation will exceed the new cost limits if their operating practices remain unchanged. Moreover, all types of home care providers will be affected regardless of geographical locale, size of agency, or level of agency efficience. Rural agencies will especially be affected. In fact, agencies who have been the most efficient and have the lowest utilization rates will have the most punitive damage done for those agencies.

The administration and Congress have already taken significant steps to discourage fraudulent, abusive practices in home health care. The BBA contained a number of anti-fraud provisions, several aimed specifically at home health providers.

Concerns about possible overuse in home care in conjunction with venipuncture, led Congress to completely eliminate coverage if venipuncture is the sole source of skilled service needed by these beneficiaries. And, I know you heard something a little different earlier, but all the information that we've read, and all the people I consulted with during the break, are in concurrence with me. We know that as a result, thousands of very frail seniors will loose their home care benefits in February, 1998, when this provision goes into effect. We expected unintended and harmful consequences, including hospitalizations and nursing home placements. Rather than eliminating an important benefit like venipuncture based on anecdotal evidence that there may be overuse, HCFA could develop a normative standard for home health services in venipuncture cases.

President Clinton announced a new initiative that includes three proposals, and you've heard about the 6-month moratorium on certification of new home health agencies; also, increasing requirements for agencies who participate in the program, including re-enrolling in Medicare every 3 years; and a doubling of audits of home health agencies. NAHC supports the concept of a moratorium on certification of new Medicare home health agencies. We believe some type of temporary hold is necessary in order to introduce new standards for providers. We are concerned, however, about HCFA's implementation of this moratorium. We strongly believe that exceptions are essential to guarantee both availability of care as well as patient freedom of choice, especially in the rural areas.

We in the home care industry understand Congressional concern about growth in the Medicare home care program. We believe it's vital to the future of the benefit that unnecessary utilization of the benefit be curtailed so that care to those who truly need it is available. But, we must all keep in mind that there are a number of legitimate factors, such as the aging of the population, the hospital DRG system, and advances in medical technology which have contributed to the growth in the home care benefit. But, even without the recent enacted changes in BBA, home health gross has been projected to moderate and fall to around 6 percent by the year 2000.

NAHC recently called together more than 200 home health agencies and hospice leaders from across the Nation to develop a strategic plan, and many of the people on your panel today were with us during that time, and we were taking a comprehensive approach to fraud and abuse. Some of the recommendations include: factors that would affect both providers, law enforcement agencies, consumers, and policymakers, while some of those are the institutional corporate compliance plans by all home health agencies to ensure adherence to all Federal and State laws; mandatory screening and background checks on all applicants for Medicare certification as a home health agency, as well as all employees of home health agencies; and establishment of a National registry; strengthening of program participation standards to include credentialing and competency testing of home health agency personnel responsible for maintaining compliance with Medicare standards; and the investment of sufficient government and industry resources to expedite and ensure appropriate implementation of a workable prospective payment system that eliminates existing incentives for inefficiency and over utilization of services.

NAHC hopes the recommendation in the strategic plan will assist Congress and the administration in their efforts to ensure both access to high quality needed home care and to restore the integrity of the home health benefit. And, we ask that you reject policies that restrict the benefit or punish unlawful providers.

And, I do want to say, since someone asked earlier about milestones that HCFA might have in implementing PPS; in our testimony on page 7 and 8 you will find benchmarks that we've proposed for monitoring that.

[The prepared statement of Mary Suther follows:]

PREPARED STATEMENT OF MARY SUTHER ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Thank you for the opportunity to present testimony today on issues relating to the Medicare home health benefit. My name is Mary Suther. I am the Chairman and Chief Operating Officer of the Visiting Nurse Association (VNA) of Texas. I am also chairman of the Board of Directors of the National Association for Home Care (NAHC) and have served as Chairman of NAHC's Prospective Payment Task Force and as a member of NAHC's Task Force on Fraud and Abuse. I would like to commend you, Mr. Chairman, and members of the Subcommittee for holding a hearing on such an important topic.

NAHC is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's members are every type of home care agency, including nonprofit agencies like the Visiting Nurse Associations, for-profit chains, hospital-based agencies and freestanding agencies.

The National Association for Home Care does not deny that there is fraud in the home care industry. For every dollar of home care fraud, there is a dollar less to be spent on delivering care to needy beneficiaries. For that reason, NAHC has a zero tolerance policy on fraud, waste, and abuse.

NAHC recently convened a meeting of leaders in home health to specifically address the issue of combatting fraud in the industry. The result of this meeting was the development of a strategic plan of action that industry, consumers, law enforcement and policymakers can use as a guide to formulate initiatives to curb home health fraud. An abridged version of NAHC's strategic plan is attached to this testimony.

The significant growth in the home health benefit has led to Congressional questions about fraud and abuse in the industry. Recent provisions in the fiscal year (FY) 1998 budget and other anti-fraud initiatives were designed to limit utilization of home health services and curb the growth of the benefit. These changes will profoundly transform the home health benefit as we know it.

Before Congress considers further changes to Medicare home health we urge that you assess the impact of the new provisions on the benefit. The new reimbursement structure coupled with stringent requirements designed to curtail fraud will force home health providers to drastically alter the way they do business and deliver care to home health beneficiaries. This testimony analyzes the potential impact of these provisions and outlines the anticipated changes in behavior by home health providers in adapting to the new regulations and cost structure.

I. INTERIM PAYMENT SYSTEM (IPS) AND ITS IMPACT

A. IPS

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) dramatically reshapes the reimbursement structure of the Medicare home health benefit. While the legislation retains cost-based reimbursement, it changes the way home health agencies are reimbursed. The interim payment system (IPS) will remain in effect until a new prospective payment system (PPS) is implemented for cost reporting periods on or after October 1, 1999. In total, the Congressional Budget Office (CBO) estimates that the new Medicare home health reimbursement system will achieve $16.2 billion in savings over the next five years, a 13% reduction in projected outlays for home health.

Under IPS, home health agencies will be paid the lowest of: (1) their actual, reasonable costs; (2) the per-visit cost limits; or (3) a new blended agency-specific per-beneficiary annual limit, applied in the aggregate to the agency's unduplicated census count of Medicare patients.

The IPS also reduces the cost limits in two ways. First, they will be calculated based on 105% of the median per visit costs of freestanding home health agencies (HHAs), rather than the previous method of 112% of the mean. Second, the new cost limits will not take into account the market basket price increases that occurred between July 1, 1994 and June 30, 1996. The combined effect of these two provisions results in cost limits that are on average approximately 15% lower than otherwise expected. The range of reductions is 14% to 22%. Skilled nursing and home health aide limits are expected to be reduced by approximately 14% in both urban and rural locations.

B. Impact of IPS on Home Health Agencies and Beneficiaries

Home health agencies will need to drastically alter their behavior to survive under the new reimbursement environment. NAHC estimates that 75% of home health agencies currently in operation will exceed the new cost limits if their operating practices remain unchanged. Moreover, all types of home care providers will be

affected, regardless of geographical locale, size of agency, or level of agency efficiency.

To be a viable agency under IPS, home health providers will need to lower both their unit costs and the utilization of services per patient. Lowering either without adversely affecting patient care and quality of services, however, may be extremely difficult.

Home health costs have grown much more slowly than both the health care market basket and the consumer price index (CPI). Therefore, it will be very hard for providers to reduce unit costs, continue to comply with quality standards, and stay under the cost limits.

Providers will also have to reduce utilization levels which could have a drastic impact on beneficiary care. One way to limit utilization is to cut the number of visits across-the-board to all patients. This could place some Medicare beneficiaries at risk since they will receive less care than they need to remain in the home. Lower utilization will also require family caregivers to carry a larger burden. Studies show that family caregivers already provide a majority of home care services. Under IPS, their burden will increase.

To lower utilization and costs, home health providers may be forced to selectively admit patients. Beneficiaries who require high-intensity services for a short period (*e.g.* infected wound patients who require 2-3 dressing changes a day) or long-term patients who require services over an extended period (*e.g.* a multiple sclerosis patient with limited skill care needs, but who requires extensive home health aide services for help with activities of daily living) will no longer be desirable patients for home health agencies to serve. Without home care, these types of patients could end up with an increased number of acute care episodes, thus increasing costs to Medicare, or end up in nursing homes at higher costs to state Medicaid programs.

II. BALANCED BUDGET ACT AND MORATORIUM ON NEW HOME HEALTH AGENCIES

A. Balanced Budget Act of 1997

The Administration and Congress have already taken significant steps to discourage fraudulent and abusive practices in home health care. The BBA contained a number of anti-fraud provisions, several aimed specifically at home health providers:

Homebound: The BBA requires the Secretary of HHS to report to Congress by October 1, 1998, a proposal for determining the criteria and methods for determining if an individual is homebound.

Payment Based on Location Where Home Health Service Is Furnished: Home health agencies will now be required to submit claims on the basis of the location where a service is actually furnished, that is the patient's home, rather than the location of the agency billing office.

Part-Time and Intermittent Care: Effective for services furnished on or after October 1, 1997, the Medicare statute includes definitions for part-time and intermittent skilled nursing and home health aide services. For purposes of receiving skilled nursing and home health aide services, "part-time or intermittent" is defined as skilled nursing and home health aide services furnished any number of days per week as long as they were furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need of care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare's home health benefit because of need for intermittent skilled nursing care, "intermittent" is defined as skilled nursing care that is either provided or needed on fewer than 7 days each week, *or* less than 8 hours *each* day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Prospective Payment System (PPS): The budget calls for the development and implementation of PPS for home care by October 1, 1999.

Surety Bonds and Disclosure of Ownership Interest: This provision requires home health agencies to post a minimum $50,000 bond to participate in the Medicare program. The provision also mandates that home health agencies disclose identification of all officers, directors, physicians, and principal partners owning five percent or more of the agency.

Normative Standards for Home Health Claims: This provision authorizes the Secretary of HHS to establish, through regulation, normative guidelines for the frequency and duration of home health services. Additionally, the Secretary is authorized to establish a process for notifying physicians in cases in which the number of home health service visits provided under the physician's plan of care exceed these thresholds.

Venipuncture: This provision revises the definition of skilled home health services to specifically exclude venipuncture (blood drawing) from the eligibility criteria for intermittent skilled nursing services.

NAHC has a number of concerns about some of these budget provisions. For example, NAHC supports efforts to strengthen the admissions requirements for participation in the Medicare program. However, NAHC believes that an accreditation program, which predicates Medicare participation on broad based competency, would be a more effective bar to entry by unqualified providers than a surety bond requirement which allows access to Medicare based solely on financial capital.

NAHC also agrees that Medicare payments should more closely reflect the costs of care in the places where those tasks are performed. The budget provision calling for payment based on the location where the home health service is furnished, however, only recognizes the varying labor costs that occur specific to the site of care. Labor costs for billing, clerk functions, and other activities that are carried out in an agency office should also be reflected in an agency's reimbursement levels.

NAHC doubts that HCFA is able to develop appropriate normative standards for home care on a broad scale at this time. HCFA currently lacks sufficient information to develop a case mix adjuster for home care which is why a prospective payment system is not yet feasible. The same information would be needed to develop workable normative standards. We propose that HCFA begin in only a few areas. For example, HCFA could start by developing normative standards for venipuncture.

Concerns about possible overuse of home care in conjunction with venipuncture led Congress to completely eliminate coverage if venipuncture is the sole skilled service needed by these beneficiaries. We know that, as a result, thousands of very frail seniors will lose their home care benefits in February, 1998, when this provision goes into effect. We expect unintended and harmful consequences, including increased hospitalizations and nursing home placements.

Rather than eliminating an important benefit like venipuncture based on anecdotal evidence that there may be overuse of other supportive services, HCFA could develop a normative standard for home health services.

B. President's Moratorium on New Home Health Agencies

On September 15, 1997, President Clinton announced a new initiative that includes three proposals: (1) a six-month moratorium on the certification of new home health agencies, (2) increased requirements for agencies who participate in the program including re-enrolling in Medicare every three years, and (3) a doubling of audits on home health agencies. By taking such a drastic and unprecedented step, the Administration stated that it hopes to rid the home health program of "fly-by-night" operators and discourage overutilization.

NAHC supports the concept of a moratorium on the certification of new Medicare home health agencies. We believe some type of temporary "hold" is necessary in order to introduce new standards for providers. We are concerned, however, about HCFA's implementation of the moratorium. We strongly believe that exceptions are essential to guarantee both availability of care as well as patient freedom of choice.

HCFA's guidelines fail to recognize providers who were in the process of seeking initial certification when the moratorium was announced. The procedures for securing initial Medicare certification require establishment of a functioning home health agency. Many of these prospective Medicare providers have invested considerable time and human and financial resources to establish their home health agencies and serve patients, many of whom are Medicare beneficiaries that are receiving care at no cost to the program.

NAHC, therefore, has requested that exceptions to the moratorium be made in the following circumstances:

- *Providers in rural or underserved areas.* The moratorium must allow new agencies to open in areas where little or no care exists at present.
- *Prospective new providers who have been awarded certificates of need (CoN) by their state.* About half of the states require new providers to apply for a CoN prior to beginning operation. CoNs are only issued in cases where the state finds underserved or unmet needs that the new provider could meet. These providers have already successfully demonstrated the need for their services by engaging in the time-consuming and costly process of filing for a CoN. Therefore, no further test should be applied.
- *Prospective new providers who have made an official request for a survey.* These providers have invested considerable resources to establish their agencies to meet the Medicare conditions of participation with the expectation that their survey would occur within a reasonable period of time. To delay that survey for six months or more would be an injustice to these providers and the patients

that they are serving. There may also be some providers who are post-application but pre-survey request who have invested significant resources and should be considered for an exception.

- *Existing providers who wish to open a new branch office.* Opening of branch offices to provide services within the geographic area of the parent does not constitute an expansion of services. Rather, a branch office may provide for more efficient and effective delivery of care and supervision of personnel in distant parts of the parent agency's service area. By definition, a branch office is totally under the control of the parent agency.
- *Existing providers with already established and previously approved branch offices that have been told to convert these offices to subunits or parents.* To subject these branch offices to the moratorium will result in serious disruption in service to Medicare beneficiaries with transfer of patients to other providers or, in some cases, unavailability of needed services.

III. HCFA ACTIONS TO PREVENT FRAUD

A. Need for Administrative and Enforcement Improvement

While there is evidence of noncompliance by home health agencies, Medicare contractors and enforcement agencies have also failed to adhere to appropriate standards in administering the home health benefit. Reports from home health agencies of Medicare intermediary errors in claims processing, coverage determinations, and cost report audits have drastically increased.

In 1996, increased program errors led to an additional 8,000 appeals from the previous year, an additional 2,300 administrative law judge hearings, and an increase of appeal reversals to 81.5%. Many of these appeals occur because Medicare ignored the evidence of the record or based its determination on unwritten and irrational policy positions. For example, one Medicare intermediary has unilaterally chosen to deny all claims where the physician's orders are "date stamped" upon receipt by the home health agency but the stamp does not include the word "received." Similarly, the intermediary has rejected claims because the provider utilized a computerized claim log which records both the date and time the care orders are received instead of using a rubber stamping system. Another intermediary is rejecting claims on the basis that the clinical records were not received by the claim reviewers within the requested time frame even though the intermediary's mail room had received them well before the required date. There are no rules, regulations or policy statements which support the intermediaries' determinations in such cases.

The administrative errors which plague the Medicare system pale in comparison to the harm caused by unfounded and potentially malicious fraud investigations by government agents attempting to destroy a home health agency. A case in point involves a non-profit North Carolina provider. A federal search warrant led to seizure of nearly 5 million pages of records from the agency. However, the search warrant was challenged in federal court where, after 15 months, it was established that the federal agents had misled the judge with insupportable claims in their affidavits. In the court's ruling, it was found that on eight separate occasions the federal agents had acted with a "reckless disregard for truth." Overzealous and misguided government investigations can be fatally dangerous to a home health agency as well as the patients it serves.

Remedies designed to address fraud, waste, abuse and noncompliance in the home health benefit must be balanced with administrative accuracy and accountability to the public and providers alike.

B. HCFA's Development of a Prospective Payment System (PPS)

NAHC has serious concerns that HCFA will be unable to meet the October 1, 1999 deadline for developing a PPS for home health. The current schedule for HCFA's case mix study is as follows:

Data collection began October 1 and 15, 1997. Twelve months of data collection is to be completed on September 30 and October 14, 1998. However, all data will likely not be submitted until mid-November 1998 at the earliest. Initial analysis of the first 12 months of data is scheduled for October 1998 to January 1999. However, because of the lag for data submission, this probably will not occur until December 1998. Data collection will then continue for another six months (until mid-April 1999).

The current schedule for the per episode PPS demonstration is as follows:

This is a three-year demonstration to be completed by all agencies by December 1998. Preliminary results are due by the end of 1997 and the final report is due in 1999.

Implementation of the PPS requires using the data on case mix to develop the payment policy. This cannot happen until the case mix data is analyzed (after January 1999). PPS is scheduled to be implemented for cost reporting periods beginning on or after October 1, 1999. In order to give HHAs appropriate notification, the regulation should be published no later than July 1, 1999. It takes a minimum of six months for regulations to go through the clearance process which means the notice would need to be ready by January 1999 in order to give HHAs three months notice.

NAHC recommends the following benchmarks to track HCFA's progress on developing PPS for home health services:

January 1998—Are the case mix study agencies completing and submitting data accurately and as scheduled? (If there are problems with the study, meeting time lines for analysis will not be possible).

January 1998—Are the preliminary results from the per episode demonstration reported? Is the PPS demonstration on schedule with all agencies reporting data accurately and on time?

April 1998—Has HCFA developed (in keeping with its schedule) the PPS regulation incorporating the clearance process including content, responsibility, and time line.

July 1998—Has HCFA developed a conceptual approach and/or process for using case mix data and the per episode demonstration information in developing the payment system, as well as plans for a transition system for up to four years? How will HCFA use the final six months of case mix data collection to revise the payment system? What are their plans for including industry input? What will they do if the research is unsuccessful in developing a case mix adjustor?

November 1998—Is all data for the first twelve months of the case mix study reported?

January 1999—Is all data for the PPS demonstration reported?

March 1999—Has a Notice of Proposed Rulemaking been published?

July 1999—Has a Final Regulation been issued?

C. Medicare Transaction System (MTS)

HCFA must also ensure a claims processing system that will identify fraud prior to reimbursement and act as a credible deterrent to unscrupulous providers. HCFA has spent the last several years developing the Medicare Transaction System (MTS), which they hoped would consolidate the 72 different contractor payment systems into a central system to improve payment needs of beneficiaries and fight fraudulent and abusive billing practices. The MTS project, however, has been plagued by cost overruns, mismanagement, and delays in implementation. In fact, this Subcommittee has been instrumental in uncovering the problems with MTS and bringing them to the attention of the American people. As a result, HCFA has recently terminated the primary contractor on MTS and the status of the entire project is in jeopardy.

NAHC urges HCFA to downgrade the priority or terminate the development of MTS and adopt readily available commercial software that will be able to detect fraudulent and inappropriate billings. A General Accounting Office (GAO) report entitled, "Commercial Technology Could Save Billings Lost to Billing Abuse" (May 1995), recommended that HCFA require Medicare carriers to use a commercial software system to detect code manipulation and fraudulent billing schemes when processing Medicare claims. According to the GAO, commercial software is currently available and can be adaptable to match Medicare payment policies. Implementation of such commercial software has the potential to save Medicare over $600 million a year, compared with acquisition costs of about $20 million. Moreover, a claims processing system that can detect fraud and billing errors prior to reimbursement will provide an important deterrent to providers who feel that they can move from region to region, abusing the Medicare program, without fear of reprisal.

D. Physician Involvement

NAHC has long encouraged greater physician involvement in home health care. NAHC has worked with both HCFA and Congress in ensuring that physicians receive appropriate reimbursement for home care patients who require extensive medical management services. As a result, in 1994, HCFA amended the physician fee schedule to include payment for care plan oversight services involving home health and hospice.

NAHC, however, does not support recent OIG recommendations calling for mandatory physician office visits prior to home health certification. Patients who are eligible for home care services are, by definition, homebound. Requiring these beneficiaries to submit to travel to a physician's office would constitute a severe hardship to non-ambulatory patients. Moreover, in some rural areas, the doctor's office could be a hundred mile round trip and require an ambulance or special vehicle for trans-

portation. A mandatory office visit requirement would also add tremendous costs to the Medicare program.

Moreover, there has been no evidence of program abuse as a result of Medicare's long-standing position that the patients seek physician services only where an actual need for care arises. For over 30 years home care providers have been the eyes and ears of physicians, conveying necessary clinical information on a continuous basis. The existing conditions of participation establish ongoing reporting responsibilities and monthly progress reports. Mandatory physician visits will only burden homebound patients and increase Medicare expenditures.

IV. GROWTH IN HOME CARE

We in the home care industry understand Congressional concern about growth in the Medicare home health program. As I mentioned earlier, we believe it is vital to the future of the benefit that unnecessary utilization of the benefit is curtailed so that care goes to those who truly need it. But we must all keep in mind that there are a number of very legitimate factors that have contributed to growth in the home care benefit.

The Medicare home health benefit has been an evolving benefit for most, if not all, of its existence. In Medicare's earliest years, home health expenditures amounted to one percent of the total. Today, home health comprises close to 10% of total Medicare payments. Therefore, while the benefit has increased each year, it still represents a small proportion of Medicare spending.

In 1996, nearly 4 million Americans received Medicare home health services, representing an estimated $18 billion in Medicare spending. Much of the increase over time can be attributed to Congressional and legal actions that were specifically designed to allow more individuals access to in-home services.

Even without the recently enacted changes in the BBA, home health growth has been projected to moderate and fall to more modest levels in the next few years. The Health Care Financing Administration (HCFA) Office of the Actuary expects annual growth in the volume of visits to steadily decrease to around six percent through the year 2000.

Reductions in Hospital Lengths of Stay. Growth in the home health benefit must not be looked at in isolation. There is a direct connection between the implementation of the prospective payment system (PPS) for hospitals and the growth in the home care benefit. PPS has made it in the hospitals' best interest to move patients out of hospitals as soon as possible, and to collect the full diagnosis related group (DRG) payment for fewer days of care. In fact, over the last six years, lengths of stays in hospitals fell 31% in the DRGs most associated with post-acute care use. Much of the growth in the home health benefit has resulted from quicker discharges of more acutely ill patients from hospitals to home care, and in some cases, avoidance of hospital treatment altogether.

Coverage Clarification. In the mid-1980s, HCFA adopted documentation and claims processing practices that created general uncertainty among home health agencies about what services would or would not be covered. The result was a "chilling effect" under which some home care claims were diverted to Medicaid and some Medicare patients went without care. This "denials crisis" led in 1987 to a lawsuit (*Duggan v. Bowen*) brought by a coalition led by Representatives Harley Staggers and Claude Pepper, consumer groups, and NAHC.

The successful conclusion of this suit led to a rewrite of the Medicare home health payment policies. Just as lack of clarity and arbitrary payment decisions had depressed growth rates in the preceding years, the policy clarifications that resulted from the court case allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is clear. The first upturn in visits (25%) came in 1989 when the clarifications were announced; and an even larger increase took place (50%) in 1990, the first full year the new policies were in effect.

Cost Effectiveness. Home health has evolved beyond its traditional boundaries, making it possible for home health providers to prevent, reduce or eliminate altogether a patient's need for costly inpatient treatment. It is also important to note that while home care has experienced growth in the number of visits provided per patient, home care's costs have remained steady over the last decade, making home care still one of the best health care buys.

An Aging Population. As the U.S. population ages, the need for home health services will grow. Older individuals are more likely to need home care and they are likely to use more home care services than younger home health patients. For example, the National Medical Expenditures Survey found that individuals over age 85

are three times more likely to use home care than the general elderly population, and their resource consumption is also significantly higher. Individuals over age 65 used an average of 65 visits whereas individuals over age 85 used an average of 75 visits.

Improved Access. Throughout much of the 1980s, the home care industry, along with the rest of health care, was experiencing a personnel shortage. Although there are still acute shortages of certain disciplines, conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 9,923 in 1996. Although access problems still exist in some states, for the most part patients who need home health care now have access to it.

Public Awareness and Preference. The past decade has seen a dramatic increase in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery of health care services. For example, a 1985 survey found that only 38% of Americans knew about home care; by 1988, over 90% of the public understood home care to be an appropriate method of delivering health care, and supported its expansion to cover long-term care services as well. A 1992 poll found that the American public supports home care by a margin of nine to one over institutional care. Nearly 82% of all accredited medical schools now offer home health care training in their curricula.

Technological Advances. Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances has been the introduction of home infusion therapy and radical improvements in ventilator equipment.

V. CONCERNS ABOUT AND EFFORTS TO ADDRESS FRAUD AND ABUSE

A. NAHC's Policy

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved—patients, payors, and providers—to aggressively uncover, report, and act against fraudulent or abusive home care providers.

A distinction must be made, however, between willful fraudulent activity and unintentional failure to comply with Medicare regulations. For example, the Office of the Inspector General (OIG) often characterizes as fraud billing for services that do not appear to meet Medicare reimbursement requirements related to medical necessity. Yet, determinations of whether care is medically necessary are, by their nature, subjective and not an exact science. Allegations, therefore, need to distinguish fraud from human error.

NAHC has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education, cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In addition, NAHC has initiated an outreach effort to educate consumers and policy makers on fraud issues, including development of "Consumer Tips for Recognizing, Preventing, and Reporting Fraud and Abuse" (Attachment 1). This pamphlet is a guide for educating patients about the need to protect their health benefits and to help beneficiaries recognize and report suspected fraud in home care.

In January 1994, NAHC implemented a broad new policy governing member conduct. (*See* Attachment 2, National Association for Home Care, Code of Ethics). While America has embraced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers who seek to profit at public expense. The incidence of fraud in home care is low. However, even a single occurrence of fraud or abuse is not acceptable and must be eliminated.

B. NAHC's Efforts to Combat Fraud

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of acceptable standards of conduct. Internal audits and self-enforcement must be performed to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to make this education as widely available as possible.

NAHC believes that increased public awareness is a valuable means of oversight and that the public must be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. NAHC has not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concern.

One of the most important roles that the home care industry plays in eliminating fraud and abuse is to lend its knowledge and expertise to enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest level, NAHC has put individuals and providers who have evidence of fraudulent conduct in touch with the Department of Health and Human Services (HHS) Office of Inspector General (OIG). On a deeper level, NAHC has provided guidance to enforcement authorities on areas in which resources might be targeted in their home care efforts.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billing for services never rendered, and kickbacks for referrals. These types of fraud are now being joined by an entirely different form of abuse found in managed care. In the traditional fee-for-service system incentives exist for overutilization and overcharging. Managed care may create financial incentives to improperly underutilize care. The health care consumer is harmed doubly in these circumstances: *financially,* care is prepurchased but not delivered; and *healthwise,* necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of abuse. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

C. Operation Restore Trust and Its Impact on Home Care

Home care has come under increased scrutiny through the Administration's anti-fraud initiative, Operation Restore Trust (ORT). While well-intended, this is reminiscent of the "denials crisis" of the 1980s where allegations of overutilization, non-covered services and waste, fraud and abuse severely affected access to necessary home care and hospice services.

Congress confronted the "denials crisis" by appointing a commission to study the impact of arbitrary denials on Medicare home health beneficiaries. *The Report to Congress and the Health Care Financing Administration from the Advisory Committee on Medicare Home Health* (July 1, 1989), found that poorly designed budget-savings initiatives, inconsistent interpretation and reinterpretation of Medicare criteria, and increased fiscal intermediary review of home health claims were just some of the factors that created a "chilling effect" causing home health agencies to discontinue services and deny care in order to avoid arbitrary denials.

Similarly, as a result of ORT practices, some home care agencies are currently being terminated based on unwritten and arbitrary standards that are inconsistent with long-standing written rules. Moreover, agencies are unable to protect themselves because their rights to appeals and hearings only manifest after termination. By then, it's too late.

Improper administrative efforts are highlighted in the case of CSM Home Health Services. CSM was terminated from the Medicare program after three federal surveys found alleged noncompliance with the Medicare conditions of participation. The termination took effect in July 1996. CSM appealed to an Administrative Law Judge (ALJ) who reversed the termination on October 25, 1996. Medicare appealed the ALJ decision. The appellate level agreed with the ALJ and reinstated CSM in an August, 1997 decision. Since July 1996, however, CSM was prohibited from serving Medicare patients. By the time the appeal was resolved, it was too late for CSM's business as it was bankrupt. Reports have now surfaced that the same federal surveyors are continuing to apply the same invalidated regulatory interpretations in Arizona.

While the anti-fraud initiatives of ORT certainly have merit, the OIG and other enforcement agencies must ensure that necessary and desirable utilization should not be curtailed in the name of eliminating fraud and abuse.

D. Overstatement of Home Health Fraud

NAHC and the vast majority of the home care community applaud efforts to rout out fraud and abuse and prevent their occurrence. However, neither home care beneficiaries nor providers are served well by efforts to exaggerate the incidence of fraud. Recent OIG reports have estimated home health noncompliance at 40% of total services claimed. (*See* OIG, "Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York, and Texas" July,

1997 and OIG, "Home Health Problem Providers and Their Impact on Medicare" July, 1997). In one study, the OIG focused only on agencies predetermined to be problem home health agencies. The other study reviewed only 250 home health claims. Because the studies deal with either problem providers or such a small sample, we strongly believe that the findings are not applicable to the industry as a whole.

It is also important to note that a majority of claims cited involved unintentional failure to comply with Medicare regulations. For example, the OIG found services did not meet Medicare requirements because of questions as to medical necessity, homebound status, lack of documentation, and incomplete physician orders. Rather than fraud, these reports represent the OIG opinion that home health agencies are not compliant with coverage rules—more likely unintentional errors than intentional acts of fraud.

Moreover, recent data shows that Medicare intermediaries reverse 40% of such claims during reviews of their own denials and administrative law judges—judges who hear appeals involving Medicare claim denials and certification of Medicare-participating providers—reverse 80% of claims on appeal. While admittedly only a portion of denied claims are appealed, this provides concrete evidence that there are problems with some decisions made by intermediaries.

When developing legislative solutions to combat fraud, a clear distinction should be made between intentional fraudulent activity and technical noncompliance with the vast array of Medicare regulations. NAHC believes that it is vitally important that Congress address noncompliance issues, but urges that different methods be used to address noncompliance as opposed to intentional fraud. Administrative deficiencies in the Medicare program which have lead to wrongful claim denials must also be corrected.

VI. NAHC'S RECOMMENDATIONS TO COMBAT FRAUD AND ABUSE

NAHC recently called together more than 200 home care and hospice leaders from across the nation to develop a strategic plan that takes a comprehensive approach to fraud and abuse. A summary of the plan, which is attached to our testimony (See Attachment 3, National Association for Home Care, Summary of the National Association for Home Care's Antifraud Strategic Plan), outlines specific actions that can be implemented by NAHC, individual agencies, state home care and hospice organizations, regulators, legislators, and consumers. All of these groups share in the responsibility of returning accountability to the Medicare program.

NAHC hopes these recommendations will assist Congress and the administration in their efforts to ensure both access to high quality needed home care and to restore the integrity of the home health benefit.

CONCLUSION

NAHC urges Congress to consider preventive measures to combat fraud and abuse along with the new anti-fraud laws. Preventive measures directed at the systemic problems that allow fraud and abuse to occur will gain more for the Medicare program than efforts which merely increase sanctions against offending parties. Moreover, NAHC urges Congress to reject policies that restrict the benefit or punish lawful providers in the attempt to combat fraud. Congress should also allow the legislative and regulatory changes recently enacted to unfold before additional action is undertaken. The dramatic payment reforms enacted in the BBA will require a complete alteration of antifraud efforts as the incentives are reversed to encourage underutilization, rather than overutilization, of services. Once again, thank you for the opportunity to testify. We look forward to working with you.

Mr. BARTON. Does that conclude your oral testimony?

Ms. SUTHER. Yes.

Mr. BARTON. Okay. I didn't know.

Okay the Chair is going to recognize himself for the first 10 minutes of questions.

A general question to each on the panel: what do you all think about being a part of an industry that apparently has got a 40 percent fraud, waste, and abuse rate?

Mr. CENAC. Well I'll start; I guess I was first.

We heard the testimony by the OIG and their inference that the sample was random. I'll start with that. I think you may recall also

the testimony of HCFA when Ms. Ruiz said under testimony that who do you think identified the providers. I'm not a great statistician, but I know random has to be random and cannot be identifying providers. That's No.1.

No. 2, you've heard Mr. Pyles' testimony as to what was cited in the North Carolina case, and also what Dr. Coburn has shared on the identification—or lack of identification—of what is defined as a bed-bound patient. And to me, bed-bound might be the wrong word; we like using the word homebound. But, when the government can come in and say: look, we've hired Medicare intermediaries to go in—and that's what the OIG said, the very same people who review our claims——

Mr. BARTON. Now, I've got 3 other people, and I've only got 10 minutes.

Mr. CENAC. Okay, sorry.

Mr. BARTON. Are you happy with 40 percent, unhappy with 40 percent?

Mr. CENAC. I disagree strongly that 40 percent is even an accurate figure, in terms of——

Mr. BARTON. Well, what's your figure?

Mr. CENAC. In terms of fraud, waste, and abuse? I believe that we would probably fall in the norm of the 14 percent category that other health care providers——

Mr. BARTON. There's no documentation on that?

Mr. CENAC. Oh. You said what's my figure.

Mr. BARTON. Well, I could pull a figure. I can say my figure's 1 percent.

Mr. CENAC. Well, if I use the testimony of people who are found guilty, No. 1, the number of claims that were denied in home care was less than .2 percent. And——

Mr. BARTON. Well, that may very well be part of the problem, that more claims aren't denied.

Mr. CENAC. The other thing that I've emphasized is when I look at the waste and abuse, hospitals are overcharging—they cost more than 50 percent more than a free-standing facility. One of the cases given by the FBI, Mederi, what was not cited is maybe what was the motive in Mederi driving the——

Mr. BARTON. So, your position, your association that you represent, is that it's really not a problem.

Mr. CENAC. No, that's not the case. I believe that fraud is a problem and abuse is a problem. In fact, we've asked to be put on a committee to help HCFA root out fraud and abuse, and they flatly refused that offer.

Mr. BARTON. Mr. Pyles?

Mr. PYLES. Yeah. We're deeply disturbed by the 40 percent figure. When it came out we found it shocking. And, one of the first things we did was to ask all of our members to intensify efforts to have not only corporate compliance plans but regulatory compliance plans. Because, I think that probably is a large part of what is going on.

You heard Dr. Coburn quite appropriately say there is a stack of laws and regulations this high that apply to home health. And there is. And if you send investigators out to spend all the time they want to spend interviewing physicians, interviewing the pa-

tients, not interviewing the agencies, to find if there anything in that stack that is a problem that would allow them to deny a claim, I think you probably will find a fairly high percentage. I think if you did that kind of review of any of Dr. Ganske's or Dr. Coburn's colleagues you'd find a similar finding with the same—if you look for any problem with any claim.

But, that's not to say there's not a problem. I think there probably is. I think it's probably, mostly, largely a documentation problem. I think there are problems of fraud and abuse. But even with the documentation, we've got to correct it. And we are trying to do that with a regulatory compliance plan.

I'll tell you another figure—you asked for data. The figure I find much more persuasive is the rate of reversals at the administrative law judge level when a home health agency takes an appeal. That is, every claim that's denied is subject to a review on appeal if you want to take it that high to an administrative law judge. The cases that get there are self-selected by both the government and the provider. These are cases that the government thinks are strong, otherwise they would have paid them; these are cases that the agencies think are strong or they wouldn't have pursued the appeal that far. This is the first step in the appeals process where all evidence is presented to an independent trier of fact. When that happens, 88 percent of those cases are decided in favor of home health agencies. Now, that is far different from the 40 percent.

That's why the 40 percent figure—we're concerned about it—but I ask you, and I beg you, look at that figure skeptically. That figure is based on a recommendation of what should be done with claims that we're previously found covered. These are claims that have not—there's no determination that's been rendered in them. No appeal has been taken. They haven't had—all parties have not had an opportunity to present evidence before an independent trier of fact.

So, there's probably a percentage there somewhere, but that is not—that 40 percent figure is not based on claims that have been finally adjudicated in that way. As a matter of fact, we have to assume, until those claims are reversed—because they just reviewed claims that were found covered—until those determinations are reversed, we must assume the 40 percent figure is wrong.

Mr. BARTON. So what's you figure?

Mr. PYLES. Because all we have is—what's that?

Mr. BARTON. What's your figure?

Mr. PYLES. Well, I think it's somewhere between 40 percent that should be denied, and 88 percent should be paid. And, I think if you take the 88 percent figure—reversal rate—when all parties have a chance to——

Mr. BARTON. Of course part of that could just be you hire slick lawyers and they're able to get you off on a technicality.

Mr. PYLES. I wish that were true. But, all these cases involve $200 or $300 a shot. And no lawyer appears at those cases. These are all presented by home health personnel before administrative law judges. There are no lawyers there—there may be at a couple of them—but the majority of these cases are just working people appearing before an independent trier of fact, presenting the facts under the law. And, so, I would suggest, you take the 40 percent

figure, and multiply it by 88 percent, and I think the remaining part of that 40 which is about 4 percent—that 40 percent—that gets you down there. I don't know. I don't know what the answer is because I don't know what's going to happen to those cases.

Mr. BARTON. You're willing to support a goal of reducing waste, fraud, and abuse verifiable, to 5 percent next year?

Mr. PYLES. If it's verifiable, but I haven't seen that yet. I would like to see what happens to that 40 percent——

Mr. BARTON. That actually gives you 1 percent to play with, if your number is right.

Mr. PYLES. Right.

Mr. BARTON. It can go up 1 percent.

Mr. PYLES. Well, I think, I think if you—I would oppose sending Federal agents into peoples' homes to see if they got home care; or Federal agents into doctors' offices every time if you want to determine whether a home health service is covered. These claims are a few hundred dollars. You're going to spend $1,500 determining whether they're covered.

We need a better system.

Mr. COBURN. Mr. Chairman, that's not an accurate assessment of what Medicare home health claims are. They may be $200 or $300 but the average home health charge to Medicare per person is far in excess of that, and it's into the thousands of dollars. And, what he describes as one of the reasons that there's a problem is that because the rules are so complicated, when HCFA gets there to court before and administrative judge we haven't given them and made the rules plain enough that they can in fact enforce it. So, you know that's a wonderful defense, if in fact you are chiseling it a little bit. The rules are so vague that, you know, you really can't——

Mr. BARTON. Well, my only point to ask the question is we have to establish a baseline and part of the baseline has got to be an acknowledgment that there is a problem.

Mr. PYLES. I would acknowledge that there is a problem, and I think Dr. Coburn has put his finger on it, and it is—one of the big problems is—the vagueness and the coverage criteria. And I think, OIG legitimately believe this 40 percent figure. And, the industry legitimately believes, and can prove, and has data to show that 88 percent of these cases are decided in their favor. So, I think the problem we have is——

Mr. BARTON. Let's let Ms. Raphael. We've got—this is my first question, and I'm already out of time.

Ms. RAPHAEL. Well, I'm not going to comment on extrapolating from the 250 cases in the sample or whether or not it targeted problem agencies. What I'm going to say is I have two reactions. And, you know, whatever the number is, I feel that it wounds my sense of professional pride in what I do, what I have devoted my professional life to do. And, I speak for all the nurses, the physicians, the physical, occupational, speech therapists, the paraprofessionals. This is something that, in fact, makes us want to hang our heads in shame.

So, that's my—you know—what ever the number is, and you know, Jim has certain things that need to be looked at and I think

that there has been generalization and sort of interlocking of fraud, abuse, and inappropriate billing.

And second, the other concern I have is that this number has led us to throw out the baby with the bath water. If you read the recent New England Journal of Medicine, it shows that there was a 44 percent drop in readmissions to hospitals for people with heart failure who had a home care intervention. I know that we can substitute for many procedures in the hospital and do them cost effectively at home, and for nursing home stays. But, because of all of this, it has put into question what I think is the tremendous value in trying to create an affordable health care system for this Nation and the role that home care can play in doing that.

Mr. BARTON. Ms. Suther?

Ms. SUTHER. I've been home care longer than anybody at this table; I've been in home care almost all my life, since the inception of Medicare, certainly. And, for a long time, home care was the greatest story never told. And now, it's the greatest story being told in a way that I prefer not to hear it being told. But, I am still proud to be part of the home care industry. The best laws are broken by the worst people, and I think we provide a tremendous service to the people we provide.

Our association is very disturbed that there is any fraud and abuse and we have established—and did establish 8 years ago—a fraud and abuse task force to come up with ways to recommend to HCFA and to the Congress ways of preventing fraud and abuse. Some of those things have been taken into consideration and regulations and rules and policies and procedures, and some have not.

Mr. BARTON. Well, my time is expired. I'm going to recognize Mr. Klink. But, I've got a whole number of questions to ask. But, I just want to state on the record as a policy statement, whatever the number is, it's unacceptable. And, you folks represent the industry that needs to be a part of the solution. I mean you come with the best interest. And, as I pointed out, with Dr. Ganske and the earlier panel, we're going to be very interactive with HCFA, and the administration, and HHS, and your associations. You're going to be given an opportunity to be interactive also.

And do not leave here thinking that the answer from your point view is just to say there's not a problem, or it's a hospital problem, or it's a reporting problem. You know, that number can be off by 50 percent, and it's still 20 percent. So, you know, we are going to get to the bottom of this. And we want solutions, not excuses. And you represent, I think, great faith in trying to help us find solutions.

But, I want to come out of these hearings with some real milestone goals. And as I told the representative from HCFA, it is not acceptable that the goal is to reduce by 4 percent over the next 5 years. That means waste, fraud, and abuse would actually grow because the program is growing faster than that.

So, we want to start focusing in, using the best faith, and come up with documentable milestones that can be monitored; it doesn't mean they have to be punitive, but I want to see a trend line that goes down so that by the year 2002, everybody accepts that it is less than 5 percent.

Social Security's failure rate is about 1.5 percent. It's the best program in the country. There is no reason that this can't be in that same order of magnitude.

Congressman Klink, 10 minutes.

Mr. KLINK. Mr. Grob, could you join us up here at the table? This is why I thought it would be helpful to me, certainly, if you would stay, and I appreciate the fact that it's been a long hearing and that you've been with us today.

I'd just like to start off, as you get yourself situated, obviously you've heard the testimony of this panel of witnesses, and their disbelief in the 40 percent number. And, I'm curious to hear your reaction to that.

Mr. BARTON. And you are still under oath. You don't need to be re-sworn.

Mr. GROB. Okay. Mr. Klink, I actually appreciate very much the opportunity that you have given me to respond.

Mr. KLINK. I thought you would.

Mr. GROB. And it is very understandable on my part, to see that people would be skeptical about a number so large. We were extraordinarily careful in constructing this as our numbers began to develop over a period of several years as we did one study after another, and we kept coming up with numbers like this. We said, could this really be true? So we gave it an awful lot of care to make sure that we were right. So, there have been five or six points raised here, and I would like to answer each and every one of them, if I may.

Mr. KLINK. Please do.

Mr. GROB. The one had to do with the randomness of the study and the remark made by Mrs. Ruiz about the selection of the problem providers. On the day that I testified before the Senate Special Committee on Aging, we simultaneously released two reports; not one. The first report was about the 40 percent error rate, and that was a truly random sample from the 4 State areas. It was completely random in its selection.

While I'm on that study, I would like to remark that several people have commented that it consisted of only 250 cases. It's a standard technique in sampling to use two stage sampling because it facilitates the review of the records. So first, you would randomly select 250, and then you would randomly select so many of that to get your larger sample. We went beyond that. After we randomly selected the 250 claims with multiple services in them, we then reviewed each and every single service within those randomly selected. So the sample was even much larger than usually done, and much finer than usually done.

Mrs. Ruiz was commenting on about the selection of targeted providers. The purpose of that other study was to identify which of the providers the HCFA carriers were watching because they were worried about them. They had their own selecting criteria. So that truly was not random; it wasn't intended to be; not to confuse that study with the other. But in fact, there was absolutely not one piece of sampling error in that study either, because in those five States, we looked at every single provider in those five States, and one by one, working with the carriers, characterized them as those that they were watching or not using their criteria. When they

were done, we wanted to make sure that we did not overstate the case, so we asked our analysts to go back through, and lay aside any of those where the categorization could have been regarded as trivial or non-consequential, or not serious. They set aside about 100 of those cases to make sure that we were not exaggerating that.

Mr. KLINK. Mr. Grob, if I could just interrupt for a moment.

Mr. GROB. Yes.

Mr. KLINK. So, in other words, you're referring to the fact that some of these were just technical documentation collections types of things: dates on the wrong line, not signed correctly? So, you're saying those were dismissed?

Mr. GROB. With regard to 40 percent, where it was randomly selected—I'll come back to that in a moment, because someone had talked about documentation problems.

Mr. BARTON. Be precise because he only has 10 minutes.

Mr. GROB. Yes, thank you.

I was simply saying that for the problem providers we looked at every single one. There was no sampling error in that one whatsoever, because we looked at the entire universe.

Now with regard to the documentation problem, it is true that when we do these, we sometimes find a problem of documentation. In this particular case, in the 40 percent study—the four State study—very few of the findings that we had in this particular case were based on faulty documentation. The vast majority of them were based on the medical reviews performed by the intermediaries or by the homeboundedness. There were some that were based on the inadequate physician certification, which in a few cases might have included, say, no—well it would include no signature, signed by someone other than a physician, things of this nature. Very few were what you would call a documentation of problem. Then in those cases where it was a documentation problem, you have to understand that in the business that we're in, that means that there was no evidence that any service was actually provided. It's not as if someone just kind of fussed about the documents or they weren't perfect, it meant that there was no documentation.

Now, documentation sounds like a paperwork problem, but in paying Medicare, if you don't have documentation that a service was delivered, we could hardly be in the business of simply paying anyone any time they write to us and ask us to please send them a check.

Mr. KLINK. If I could just interrupt; I'd like to know if any of our people on the other panel have a clarification themselves or a point that you'd like to make about what Mr. Grob is saying? Do you have any more confidence now that what the IG's office is saying is a 40 percent problem is in fact a 40 percent problem? Have you altered your thinking from when you were responding to the chairman's questions?

Mr. PYLES. I, for one, have not altered my thinking in any way. I agree that there is a problem. I'm not quite sure what the problem is. The problem is that, defined generally, is that Mr. Grob believes that 40 percent of the services can be—the claims can be—denied for some—one—reason or another. I think, he may be right about that. My point though is, what policy does that drive. Does

that mean the care was not rendered? Does that mean the care was not necessary? Many of the cases, I think he is going to say, I think he has said, were he thinks should not have been paid because the patient wasn't homebound. We just heard Dr. Coburn say that he meets the definition. So I think, if I may?

Mr. KLINK. Please.

Mr. PYLES. I think what he is highlighting here is a problem that has many facets. One of which is we have hopelessly, in my view, hopelessly coverage criteria that the agencies think they're doing a good job of interpreting, and Mr. Grob thinks his people are doing a good job of interpreting, and they're interpreting it 180 degrees differently.

Mr. KLINK. Alright. Mr. Grob, let me ask you again, and I thank you for staying to participate in this, how much of it is—to get to it—how much of it is a technicality and how much of it is indicative that in 40 percent of the cases there actually is a serious problem?

Mr. BARTON. Let me ask it another way. On the record of this 40 percent number, what percentage of that, in the agency's opinion, should not have been paid because it was either a service that was not provided, or a service that should not have been provided—in other words, is true waste, fraud, or abuse?

Mr. GROB. I'll have to consult the numbers, but the majority, perhaps approaching two-thirds, were for services that were not medically necessary—say about half of them were for that—and then another big hunk were for services for whom the patient was not homebound. Now those two concepts actually relate to one another, but we distinguished them because of the interest in this.

Mr. BARTON. So of the 40 percent, you would stand that somewhere between 30 and 35 percent should not have been paid by the taxpayer?

Mr. GROB. No, we would say that certainly the vast majority of the services were medically unnecessary——

Mr. KLINK. Of the 20 percent.

Mr. GROB. Oh yes. Oh, I'm sorry, of the percentage, thank you—30. Certainly that much. Yes.

Mr. BARTON. We're trying to come to a gross number.

Mr. GROB. Yes. Easily 30 percent. You know, of course, we think almost all of it. But——

Mr. KLINK. How much, Mr. Grob, relates to the vagueness that Mr. Pyles was just talking about.

Mr. GROB. Well, you know, during this hearing I never had a chance to put my 2 cents worth in on that question, and I'd like to do it now. We certainly do agree that there is a problem in the definition of homeboundness, but I would say that we haven't had all that problem in using the current definition which is what we have been using on this matter. So we agree that the definition needs to be examined. We also believe that it's possible and necessary to use the definition at hand.

And, again, I'd like to refer to Mr. Pyles. He talks about "our" people. Again, we used the intermediary, medical specialists to do this.

And, I would like to make this comment. If it's true—if it's true—that the medical experts and the intermediaries are incapable of making these judgments, then what we are saying in essence, is

that we have a $20 billion program in which nobody can tell who's bills should be paid.

Mr. BARTON. That's not acceptable.

Mr. GROB. It's not acceptable.

Mr. PYLES. That's Dr. Cook's——

Mr. KLINK. And if—well, let me turn it around; if they don't understand, should they be seeking clarification, or should they be in the business?

Mr. GROB. Again, I think they should be seeking clarification. Otherwise, I don't think they should be in the business. And I do think that it is possible to use the criteria that we have.

Mr. KLINK. Any reaction?

Mr. PYLES. Yeah, I would just say, I'll be glad to file this fro the record, but a statistic we have—that came from HCFA—indicate that at reconsideration, 40 percent of denials are reversed and the overall reversal rate at the hearing level is 80 percent, and it's not to say, again, there isn't a problem. I'm just asking you to look at those figures, because this 40 percent figure can drive wrong policy if you don't see what underlies it. And I would just ask Mr. Grob, maybe he can answer this: of the 40 percent of claims he thinks——

Mr. BARTON. Now we have witnesses asking other witnesses.

Mr. PYLES. I will suggest—I will suggest—a question——

Mr. BARTON. This is quite a hearing.

Mr. PYLES. I will suggest a question for the panel: of the 40 percent of claims that he thinks should have been denied, how many actually were denied, and how many of those denials were upheld on appeal?

Mr. GROB. Okay. All the claims that we found were turned over to the intermediaries for appropriate action. With regard to appeals, and reviews, I'd like to say a number of things about that. First of all, with regard to the ALJ appeals, it is true that about 80 percent or over are written. However, there are very, very few appeals that ever go to the ALJs. It's a very small number, indeed. I would say if you look at the number of appeals that go to the ALJs in the entire Medicare program, it is far less than 1 percent of all the appeals that are handled.

Second, the ALJ process is a non-contentious practice. The government is not represented at those hearings to present the contrary evidence.

Another thing, with regard to the denial of claims by the carriers, reference was made earlier to the audit that was done under the Chief Financial Officer's Act in which a 14 percent error rate was found across the board for HCFA—for the Medicare program. Home health, you know, was part of that 14 percent—a disproportionate part of it, as a matter of fact. The study is related to this because the method that was used is identical to the method that was used for this home health study. And, in that study they also looked at which claims the carriers should have paid, based on the documentation they received, and the answer was 98 percent should have been paid. The carriers correctly paid more than 98 percent of the bills, based on the documentation that they received. Now, what happened here, is that in this case, we went further. We went out and got the records; and we saw the patients; and we

talked to the doctors; and we got behind those records; and that's where found the error. In fact, the comparable 14 percent error across the board in that Chief Financial Officer's Act was done in the same way. They found the 14 percent error when they looked behind the documentation that was submitted to the carriers. So the intermediaries are paying the bills properly given what they're receiving; but when you look behind that, you see the problem that we are talking about.

Mr. COBURN. What you're saying is: is what they're receiving isn't necessarily a representation of the fact.

Mr. GROB. That's correct.

Mr. BARTON. Okay, the Chair is going to recognize—I believe Dr. Coburn was here before Dr. Ganske? I can't even—well, I'm going to recognize Dr. Coburn and then we'll recognize Dr. Ganske.

Mr. COBURN. I just want to follow-up and make sure I understood what you were saying while I was out of the room for a minute. It's your contention—you heard me ask, Ms. Ruiz, is there a diabetic patient in this country that's Medicare-eligible that wouldn't be eligible for home health and she said, "no."

Now, that's her testimony. There's not any dispute about that.

Mr. GROB. That's correct.

Mr. COBURN. She said, "no."

Mr. GROB. She did.

Mr. COBURN. And that's because the definition of who is covered under the benefit of the services is so broad, that I can make anybody fit into it. As a physician, I can make every one of my Medicare patients fit your guideline. And if you say there's not a problem with the definition of homebound, that's a big problem in itself. Because almost everybody, from the home health care industries, to everybody else, understands that they get hit on either side of this. They either get hit because they're treating people that they're not supposed to, or somebody can't get it because they're interpreting it wrong. So, we have a poor definition of who is available for these services and that's one of the reasons we have fraud.

Mr. GROB. Yes, Doctor, if I may call you Doctor, now?

Mr. COBURN. Whatever. Tom's fine.

Mr. GROB. Yes, we all agree that the definition needs to be looked at. We were simply saying that the intermediaries that we used for this effort, did not have trouble applying the current definition in conducting their reviews.

Mr. COBURN. Oh, yeah. It's easy. You can apply it to anybody. It's a no-brainer. Everybody's eligible.

Mr. GROB. In terms of the eligibility now, if I could get personal about it, I have a son who is a diabetic. He's not 65. But, he has a job, he works every day; by no stretch of the imagination, is my son homebound. If he were 65, I would disagree that it could be legitimately found that he would be eligible for home care under the Medicare program. Now, you're a doctor, and I think you might say that many of the elderly patients would by that time develop symptoms that could——

Mr. COBURN. As I get to 65, I don't consider that elderly.

Mr. GROB. I'm beginning to feel the same way, myself. And I do hope that we preserve this home health program for those of us who will be Medicare beneficiaries in the future.

Mr. COBURN. But I think, one of the things that we have to recognize: we've hurt some people with home health care. Because people who should be getting out, aren't. I mean, you know, there are a lot of people who sit at home say: the service needs to come to me. And that's harmful to them. They need the physical activity of getting up and getting out. That's not by any means the majority of them.

The question that I have for the entire panel: if you could design home health care, and have two or three tenants that would No. 1 meet the goals of our seniors and change what we have now, how would you do it? What are the two or three things that you would change? And I'd like for all of you to try to answer it. Mr. Pyles?

Mr. PYLES. Yeah, I have three principles. One, design a reimbursement system that has the correct incentives. You're absolutely right on when you mentioned that. Home health agencies can't compete, today, if they try to do the right thing—they'll lose patients, they'll lose revenue. So, No. 1 is enact a PPS system that has the correct incentives in it.

Second is, devote the government's resources to determining which patients are eligible. On the front end, spend some additional time deciding which patients should begin to get home health. Which ones qualify? But define home health.

Mr. COBURN. You're saying define whose eligible.

Mr. PYLES. Define homebound. Come up with better criteria that everyone understands and we don't have this disagreement that I think resulted in Mr. Grob's 40 percent figure.

Mr. BARTON. Would the gentleman yield?

Mr. COBURN. Absolutely.

Mr. BARTON. If we're just giving opinions, I think home health care should be based on the most cost effective and the best of the patients, and doesn't necessarily have to be somebody who is home bound.

Mr. PYLES. Exactly.

Mr. BARTON. If you would rather them get home health care because it's over the long term more cost effective, that's totally different from what the standard is.

Mr. PYLES. Whatever the criteria you come up with—my point is: whatever criteria you come up with, have it be criteria that everyone has a common understanding about. We worked with Dr. Coburn earlier on an addition that would have done just that: to say that home care would be available for some folks who were not homebound; where physicians felt that it would get them out of the hospital sooner, get them back on their feet sooner, even though they might not be homebound, but for a short period of time. You're absolutely right. Absolutely right.

Ms. RAPHAEL. I just wanted to comment on that because I think you have to look at home health care as inextricably linked to the rest of the health care system.

Mr. COBURN. Sure.

Ms. RAPHAEL. And, I know, Dr. Coburn, you spoke about the fact that we have increasing numbers of chronically ill individuals. And we're dealing with people who have cancer who will live for 20 to 30 years with cancer. We have to help them to live as full a life, as productive a life, as possible. And the chronic illness and the

acute episodes are interlocked, because there are points they go into the hospital, other times they're fine and they can function.

And, I thought your point, Chairman Barton, was very important. In our employer HMO plans, we are providing antibiotic therapy to people who go to work. Who have illnesses that let them go to work. They carry something that looks like a walkman, and they can self-infuse antibiotic therapy. Why should they leave work and go into a hospital for 2 weeks. So that doesn't make any sense. And, yes, they're not homebound.

Mr. COBURN. Yes.

Mr. PYLES. I guess the third point is: monitor and provide incentives for quality. We should have competition on price and quality so that there will be an incentive to provide care in a lower cost way with very high quality.

But there has to be some overarching objective for home health. What do you want home health to be for the future? What do you want it to do in this health delivery system? I think that what it should do is be a cost saver. The only way, probably, you're going to provide Medicare services to people of my generation.

Mr. COBURN. I understand. One other comment for Ms. Raphael. You have HCFA volunteers within your organization, I would suggest that you have inspector general volunteers, not HCFA volunteers. I think you would be much more effective in being clear of HCFA and its problems if you would do that.

Ms. Suther, did you have any?

Ms. SUTHER. Yes; I think that it requires much more thought to look at redesigning the system. We in the industry attempted to do that back in the early 1980's because we thought that the system couldn't be fixed at that point in time. But, on a quick draw here, I think the PPS system certainly is one of the things that can be done. But, I think more important to prevention of fraud and abuse in Medicare, is requiring a National registry for all home care workers that see patients and who own agencies. Case in point, in my own agency I found an employee that was fraudulent, I reported that employee to the provider integrity, and my intermediary, and changed the bill, and taped the action of that employee. And, that employee is now working for three other home health agencies. And, that kind of thing happens all the time. This is just a case in point.

So we need criminal background investigations on all employees, not just the ones that go into the home, but the finance directors and everyone in the agency. There needs to be a National, as opposed to a county of residence, which we have in most counties, and third, we need that National registry so people can't move from one place to another and perpetrate fraud again. It's not a lot of people doing it, but, if the same person is counted 10 times or 20 times moving from State to State, it amounts to a lot.

I've reported—one of the people that was mentioned earlier this morning by the Inspector General, he and his wife are both serving time in prison, and I reported them in 1979 on four occasions in 2 months and gave written evidence. And, nothing was done because they were too small, and the recoupment was not great enough.

Mr. COBURN. Or the rules weren't clear enough that it could be prosecuted under. And that's what Congressman Stupak's whole point is: where there's a problem, we need to have the tools to prosecute the problem. But we need to make it to where it's simple.

Ms. SUTHER. This was very clear, sir. It was clear that you can not pay physicians to refer patients, and I had copies of the letters that went to the physicians as well as copies of the Christmas cards showing the Jack Daniels cases that were going, too.

Mr. COBURN. Do you think that's going on right now?

Ms. SUTHER. Oh yes; not widespread. There are a few bad apples and they still do that kind of thing. I report people every week.

Mr. COBURN. Are most of them in my State?

Ms. SUTHER. No. You know, the other thing that I wanted to mention is: Mr. Grob, earlier, talked about, and unless I misunderstood him and he and I discussed this a few weeks ago at length, the 40 percent group that he was talking about was in those States that we're looked at, and that can not be extrapolated to other States. Was I incorrect in that?

Mr. GROB. Well, I stated in my testimony, that on a statistical basis I can not tell you what the percentage is. So, each person will have to judge for themselves.

Mr. COBURN. But, it's pretty common, that greed's about the same across every State in this country, and what we do, in fact, see in other areas where there are problems, there may be areas that are high and low. There's no question that there's a problem with defrauding home health care in every State. The degree of it, I don't care. I think, my whole point is, and I'm hopeful, and I'm hopeful in the future, we know what we need to do for our seniors, what we have to do is make the government program fit it so we can deliver it on a cost effective and beneficial way so they get what they deserve and the taxpayer gets what they deserve.

Mr. BARTON. We have 10 minutes for this vote. I'm going to recognize Dr. Ganske for the final 10 minutes, and I understand that you're only going to use about 5 minutes of that.

Mr. GANSKE. Mr. Chairman, in order for our panel to get out of here, I'm going to just make a few comments.

I think that the comment about two-thirds of the cases not being medically necessary, and one-third not being homebound, is probably true from my personal experience. I think that you can—if you want to—lay the fault at the feet of a lot of different people for the fraud, or the waste, or the abuse, however you want to define it in home health care. It starts with docs, it goes through the nurses, it goes to the patients, the hospitals, and the independent home agencies.

Now, I'll tell you how that all fits together. A lot of nurses have lost their jobs, because of hospital downsizing. A lot of nurses are employed by visiting nursing associations, Okay? When I was a physician, I'd have a patient that needed—in the hospital we were teaching them to do their suture care, their wound care, have the nurses show them how to shower, wash it, put bacitracin on, do the treatments. Then it would be time for the patient's discharge, and guess what? "Well, doc, let's refer this to a visiting nurse so that she can help the patient with the suture care at home." I said, "wait a minute, you know. All this requires is holding it under-

neath the shower, washing it with soap and water, putting some bacitracin on, and a bandage." "But you know, doc, it's free. It doesn't cost the patient a thing. Furthermore, my friend just lost her job down on ward C, that's her job."

There's no personal responsibility in this system. It gets to the definition that everyone has been talking about, and I feel that definition should be very tight. We're talking about homebound. And when you start getting into exceptions to homebound, that's where you're going to run into problems in the political system of who get what.

And then you have the problem with verifiability. Okay? So, you're the bad guy as a doc when you don't refer to the VNS for the patient that should be able to take care of themselves, or their husband or their wife should be able to do this simple job. Okay? And then, you frequently get presented with the slip to sign, ex post facto. Visiting nurse services have been out there, somehow or other. Now the slip's come in for you to sign. That's wrong. That ought to be tightened up and fixed. And people ought to have a personal stake in this, quite frankly.

Any system—any system—Mr. Chairman, where something is totally free is abused. Anyone who has operated in the military in medicine 15, 20 years ago, knows this is the case. You would have people that would come into the medical offices for a prescription for tooth paste, because if it was a prescription it was free.

I had an occupational therapist tell me that one of the biggest problems that she had—an occupational therapist with hand therapy—was that she would get an assignment to go out and help the little old lady that's out 8 miles in the country, living by herself, she's widowed, getting her hand back in shape after a hand operation, for 2 weeks. So, she'd do that, the lady's getting along fine, and she'd phone the doc, and say, "Hey, Mrs. So-and-so is doing fine. She doesn't need any more treatment." Fine. Mrs. So-and-so would then phone the doctor—Dr. Smith—and say, "You know, I really think I need more hand therapy." She didn't need more hand therapy, she needed a nice young lady to come out and visit her during the day. But, it was free. It was totally free. And that was part of the problem.

Mr. BARTON. We have about 4 minutes to vote.

Mr. GANSKE. So, Mr. Chairman, this has been a great hearing, because a lot of different views have come out. But, in summary, the points are this: A, we need a tight definition of homebound—a tight definition. We need, B, to have verifiability of that definition. And C, we need to have some personal stake in this. And if you don't have those three things, we can go around and around, but the political process will be such that there will be a lot of people that will come up with a lot of exceptions that will make this impossible to control.

Thank you.

Mr. BARTON. The gentleman yields back his time.

We want to thank this panel. You will be kept abreast of some of our interactive sessions with HCFA and the administration. And if representatives of your associations want to be a part of that, you'll be given an opportunity.

There will additional questions submitted to each of you for the record, and we would hope that you would respond in a timely fashion.

This hearing is adjourned.

[Whereupon, at 4:10 p.m., the subcommittee was adjourned subject to the call of the Chair.]

[Additional material submitted for the record follows.]

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
December 31, 1997

The Honorable JOE BARTON
Chairman, Subcommittee on Oversight and Investigations,
House Committee on Commerce
Rayburn House Office Building
Room 2125
Washington, D.C. 20515

DEAR CHAIRMAN BARTON: Thank you for your December 2 follow-up letter to the Subcommittee's hearing on waste, fraud, and abuse in Medicare home health services that was held on October 29. As you requested, we have enclosed the Health Care Financing Administration's response to the questions submitted for the record by Congressman Stupak.

We share your desire to combat fraud and abuse in the home health services benefit. I look forward to working with you on this effort as well as other areas of mutual concern. Should you or Congressman Stupak have any further questions, please let me know.

Sincerely,

NANCY-ANN MIN DEPARLE
Administrator

Enclosure

RESPONSE TO QUESTIONS SUBMITTED FOR THE RECORD BY CONGRESSMAN BART STUPAK

The following response has been prepared as requested by Chairman Joe Barton of the Subcommittee on Oversight and Investigations, Commerce Committee, on behalf of Congressman Bart Stupak.

Question 1: Many of my constituents are concerned that the new billing limits will harm patient care. For instance, Barbara Bell of the LMAS District Health Department asks:

"For the 25,000 Medicare enrollees in this seven-county region, our agency aggregate per beneficiary limit will be between $3,500 and $5,800 per year to provide home health services to our patients. Suppose a patient has a cholecystectomy (gall bladder removal) in February, suffers a fractured hip in May, has pneumonia in September, and congestive heart failure in December, all of which require home health services because he or she is 75 years old, homebound and lives alone, 45 miles from the nearest hospital or doctor's office. This is a very common example.

How do we provide the needed care in the home for the entire year for $3,500 to $5,800?"

Question 2: She raised the concerns regarding one of their patients:

"The worst case scenario is a 77-year-old woman, a former school teacher, who suffered a severe spinal cord injury leaving her a quadriplegic. She has no family or care giver and was not expected to live more than a few years. We have been caring for her in her home for over 20 years, except when she is hospitalized for more severe conditions. This woman is very proud to be in her home. She receives twice a day home health aide services for her personal care and intermittent skilled nursing. She employs a person to do her household tasks and proudly states that Medicare only pays for her necessary medical care. The cost of caring for her is around $3,000 per month. The per beneficiary limit is $5,800 per year for her area. What happens to our 77-year-old quadriplegic patient?"

HCFA Response: The billing limits that Ms. Bell describes are part of the home health interim payment system that was enacted in the Balanced Budget Act of 1997 (BBA). The interim payment system was designed to control the soaring expenditures in the home health benefit. Expenditures for this benefit are one of the fastest growing components of Medicare. In 1990, Medicare program payments for home health totalled $3.7 billion.

In 1996 dollars, this represents 2.9 percent of all Medicare payments. By 1996, home health payments grew to $16.7 billion, accounting for 8.7 percent of all Medicare expenditures. Between 1990 to 1996 the average number of visits per beneficiary more than doubled from 33 to 76.

While much of the growth in the home health benefit is due to demographic changes and medical advances, a significant amount is inappropriate. Prior to BBA, Medicare paid for all visits a HHA supplied, within a routine cost limit equal to 110 percent of the national mean of visit costs. There were no limits on the number of visits a HHA provided, as long as the visits were medically necessary. This provided an incentive to supply large numbers of short visits in order to maximize revenue and avoid the per visit routine cost limit. Visits could not be denied, unless there was medical evidence proving that the care was unnecessary. (The U.S. Department of Health and Human Services, Office of Inspector General has noted that it is difficult to prove visits are medically unnecessary).

Because of the alarming growth in home health, Congress and the Administration determined that reducing expenditures were necessary to preserve the Medicare Hospital Insurance Trust Fund and balance the federal budget. The BBA home health provisions, including the interim payment system, create incentives for HHAs to provide the appropriate amount of care that is medically reasonable and necessary. The following points offer some guidance for operating under the interim payment system.

- Beneficiaries eligible for the home health benefit should be able to receive the care they need under the interim payment system. The billing limit that Ms. Bell appears to be most concerned about is the new HHA-specific per beneficiary cost limit. Under this limit, HHAs have the flexibility to offset the cost of caring for sicker patients, who may exceed the limit, against the cost of caring for patients who are less sick and come under the cost limit. The two clinical cases presented by Congressman Stupak are the type of patients who need a considerable amount of care and may exceed the cost limit. However, the cost of caring for these patients can be offset by the cost of caring for other patients who do not require such a substantial amount of services.
  - The new HHA-specific, per beneficiary cost limit is applied in the aggregate to the count of patients. The per beneficity limit will be calculated by multiplying the number of beneficiaries by the per beneficiary limit. Applying the per beneficiary limit to the HHA overall, not just to one patient, allows the HHA to balance the cost of caring for one patient against the cost of caring for others. In addition, the new per beneficiary limits are based on HHAs' own cost experience. The per beneficiary limit is based on the HHAs' 1994 actual costs. Therefore, the limit will reflect the mix of patients, including both high and low cost, that are cared for by an HHA.
  - The new per beneficiary limit does not place a restriction on visits to individual patients. HHAs have the flexibility to provide the appropriate amount of care, including duration of visits, number of visits, and skill level of care giver within this limit.

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